

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11016

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1324 Church Hill Drive.		d. STREET ADDRESS 1324 Church Hill Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EVA Middle ABRAMS Last		4. DATE OF DEATH Month 10/19/61 Day 19 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years lost birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bare Goldscheider		14. MOTHER'S MAIDEN NAME Frieda ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Mrs. Rose Kandell-- Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 30 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19, 58 , to Oct 19, 1961 , that I last saw the deceased alive on Oct 19, 1961 , and that death occurred at 5 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6911 Park Heights Ave Baltimore DATE SIGNED ACTUAL SIGNATURE Joseph Gross M.D. PHYSICIAN'S NAME (Type) JOSEPH GROSS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/20/61	
22c. NAME OF CEMETERY OR CREMATOR Ohn Kneseth Israel Anshe		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE SOL LEVINSON & BROS INC.		24a. REGISTERED BY REGISTRAR Oct 23 61 DATE 24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11024

UNITED STATES DEPARTMENT OF AGRICULTURE

11024

OFFICE OF THE
DIRECTOR

WASHINGTON, D. C.

February 1, 1911

Dear Sir:

Very

Respectfully

Yours

Sincerely

Very

Respectfully

Very

Very

Very

Very

Very

Very

Very

Very

Very

Very

Very

Very

Very

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

11025
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

11017

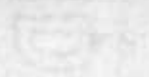
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>—</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Maryland Masonic Home</i>		d. STREET ADDRESS <i>431 N Clinton St.</i>	
3. NAME OF DECEASED (Type or print) <i>John</i> First <i>Henry</i> Middle <i>Adams, Sr.</i> Last		4. DATE OF DEATH <i>Oct.</i> Month <i>23</i> Day <i>1961</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 21, 1865</i>
9. AGE (In years last birthday) <i>95</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Blacksmith</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Benjamin Adams</i>		14. MOTHER'S MAIDEN NAME <i>Fanny Jarvis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>218-32-2918</i>	
17. INFORMANT <i>Masonic Home Records - Cockeysville, Md.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular</i> <i>422.1</i> DUE TO <i>Closure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>at least 12 yrs.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 15, 1961</i> to <i>Oct 23, 1961</i> , that (I) (we) last saw the deceased alive on <i>Oct 23, 1961</i> , and that death occurred at <i>1:15 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Elizabeth B. Sherrill</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Elizabeth B. Sherrill, MD</i>		22d. ADDRESS <i>Cockeysville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>10-25-61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Stiff Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Urbana, Virginia</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook, Inc., 1217 St. Paul Street, Zone 12</i> ADDRESS		25a. REC'D BY REGISTRAR <i>OCT 25 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>

(M)

(I)

MEDICAL CERTIFICATION

11011



CERTIFICATE OF DEATH

11022



On the 11th day of January 1901
at the residence of the deceased
the following persons were present
and witnessed the signing of this
certificate of death
The undersigned being duly sworn
deposes that the above named
persons are competent witnesses
and that the facts stated in this
certificate are true to the best
of his knowledge and belief
Signed and sworn to before me
this 11th day of January 1901
at the City of London
England
J. H. [Signature]
Registrar General

Witness, Registrar

Witness, Medical Officer

Witness, Minister of Religion

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11026

11018

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville Towson</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville Towson</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1439 Putty Hill Rd.</u>				d. STREET ADDRESS <u>1439 Putty Hill Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>CATHERINE M. Andrathy</u>				4. DATE OF DEATH <u>Oct 1 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-20-1878</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 MRS. Hours Min.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT home</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Louis J. Trier</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE FENTON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>BERNARD L. ANDRATHY</u>			
17. INFORMANT <u>same</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary sclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Marked Dehydration and wasting</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>June 5, 1958</u> to <u>Sept. 1, 1961</u> , that (I) <u>was</u> last saw the deceased alive on <u>Sept 30, 1961</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph F. Lippa</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-1-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH F. LIPPA</u>				22d. ADDRESS <u>8400 North Raven Blvd, Baltimore Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/4/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck</u>				ADDRESS <u>5305 HARFORD Rd.</u>		25a. REC'D BY REGISTRAR <u>OCT 3 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>C. J. L. KRAUS</u>	

WALL AND STATE OF TEXAS, CIVIL NO. 07-1689-01

1999

1998

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **11020**

11030

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON b. COUNTY DC.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. LENGTH OF STAY IN 1b 7 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		d. STREET ADDRESS 1407 KENNEDY STR.	
3. NAME OF DECEASED (Type or print) First HORACE Middle W. Last BARBER		4. DATE OF DEATH Month 10 Day 12 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1881
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- V.P. Suburban		10b. KIND OF BUSINESS OR INDUSTRY Title & Inv Co.	
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME SAMUEL H. BARBER		14. MOTHER'S MAIDEN NAME Ewa HART	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-01-4980A	
17. INFORMANT Personal History		Address Hospital Records, Eudowood Sanatorium	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO ARTERIOSCLEROSIS, GENERAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY TUBERCULOSIS 002X			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-4 , 19 61 , to 10-12 , 19 61 , that I last saw the deceased alive on 10-11 , 19 61 , and that death occurred at 1:25 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Milton B. Kress M.D.			
PHYSICIAN'S NAME (Type) Milton B. Kress, M.D. Eudowood Sanatorium, Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/14/61	
22c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. HINES - CO.		24a. REC'D BY REGISTRAR 2901-1475 ST. NW. WASH, D.C.	
24b. REGISTRAR'S SIGNATURE Arthur L. Hines		DATE OCT 18 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11030

NAME OF DECEASED [Faint text, possibly "JOHN DOE"]		SEX [Faint text, possibly "M"]		AGE [Faint text, possibly "45"]	
DATE OF BIRTH [Faint text, possibly "JAN 15 1910"]		PLACE OF BIRTH [Faint text, possibly "BALTIMORE, MD"]		OCCUPATION [Faint text, possibly "CLERK"]	
DATE OF DEATH [Faint text, possibly "JUN 10 1955"]		PLACE OF DEATH [Faint text, possibly "HOME"]		CAUSE OF DEATH [Faint text, possibly "HEART DISEASE"]	
TIME OF DEATH [Faint text, possibly "10:00 AM"]		SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
SIGNATURE OF NEXT OF KIN [Faint signature]		SIGNATURE OF WITNESS [Faint signature]		SIGNATURE OF DECEASED [Faint signature]	



This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be sent to the local health officer of the city or county in which the death occurred.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
11031

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11021

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hampstead</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead - Rural</u>			
c. LENGTH OF STAY IN 1b <u>40 years</u>				d. STREET ADDRESS <u>Lower Beekhollow Rd</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lower Beekhollow Rd</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clarence</u> First <u>Edward</u> Middle <u>Baumbach</u> Last				4. DATE OF DEATH <u>October 21</u> Month <u>1961</u> Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1892</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public Utilities</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Baumbach</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Sinclair</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-30-5847</u>		17. INFORMANT <u>Mrs Myrtle Baumbach</u> Address <u>Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 21</u> , 19 <u>61</u> , to <u>Oct 21</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Oct 21</u> , 19 <u>61</u> , and that death occurred at <u>9:55 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph E. Bush</u> M.D.				22b. DATE SIGNED <u>10-21-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Joseph E Bush MD</u>	
22d. ADDRESS <u>HAMPSTEAD Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 24/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace</u>		23d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Blue - Hampstead Md</u> ADDRESS				25a. REC'D BY REGISTRAR DATE <u>OCT 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

(M)

(I)

11031

CENTRAL CORDON

11031

(M)

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Central", "Cordon", and "M" are visible.]

1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11032

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11022

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8008 Harford Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 8008 Harford Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES LEE BEAN		4. DATE OF DEATH Month Day Year October 26 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1928
9. AGE (In years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Monroe Bean		14. MOTHER'S MAIDEN NAME May Barbee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 245-32-7305	
17. INFORMANT Mrs. May Bean		Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Myocardial Infarction			
4201 Conditions, if any, which gave rise to immediate cause (b) Coronary Artery Thrombosis.			
(c) Coronary Artery Thrombosis.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		M.D.	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 10/27/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/30/61	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or country) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR Leonard J. Ruck		ADDRESS 5305 Harford Road #14	
24a. REC'D BY REGISTRAR OCT 30 '61		24b. REGISTRAR'S SIGNATURE Charles S. Petty	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11033

11023

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b X Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 89 Willow Spring Road		d. STREET ADDRESS 89 Willow Spring Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle EARLE Last BEARRY		4. DATE OF DEATH Month October Day 17 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1895
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shipb ulder		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Bearry		14. MOTHER'S MAIDEN NAME Cassie M. McKenzie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 216-10-4061	
17. INFORMANT Wm/ E. Bearry		Address 2116 Merritt Blvd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 162.1 IMMEDIATE CAUSE (a) Primary Carcinoma Lungs. DUE TO (b) Carcinomatosis DUE TO (c) 7 yrs.		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 5, 1961 to Oct 17, 1961 , that I last saw the deceased alive on Oct 17, 1961 , and that death occurred at 11 A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE David H. Andrew M.D.		ADDRESS (Street, city or town, state) 33 Dundalk Ave Dundalk Md	
PHYSICIAN'S NAME (Type) David H. Andrew		DATE SIGNED 10/18/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/61	
22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Colgate, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home Dundalk, Md.		24a. REC'D BY REGISTRAR DATE OCT 20 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION

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CENTRAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11034

11024

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Reisterstown		c. LENGTH OF STAY IN 1b Since July, 1961		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Reisterstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer Park Road				d. STREET ADDRESS Deer Park Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mr. Harry		First Mr. Harry Middle F. Last Becraft		4. DATE OF DEATH Month Oct. Day 2 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1888		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Weaver		10b. KIND OF BUSINESS OR INDUSTRY Textile Bus.		11. BIRTHPLACE (State or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Becraft				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-03-1994		17. INFORMANT Mrs. Margaret W. Becraft, Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 15 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July 16, 1961 , to October 2, 1961 , that (I) (we) last saw the deceased alive on October 2, 1961 , and that death occurred at 3:20 PM , from the causes and on the date stated above.							
22a. SIGNATURE Clarence E. McWilliams				22b. DATE SIGNED October 2, 1961		22c. PHYSICIAN'S NAME (Type) Dr. Clarence E. McWilliams	
22d. ADDRESS 11904 Reisterstown Rd Reisterstown, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/5/61		23c. NAME OF CEMETERY OR CREMATORY Old Oakland M.E. Church		23d. LOCATION (City, town, or county) (State) Carroll Co. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				25a. REC'D BY REGISTRAR DATE OCT 6 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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DEPARTMENT OF HEALTH

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CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11035						11025					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY Baltimore						a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard						b. COUNTY Baltimore					
c. LENGTH OF STAY IN 1b 15 Days						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						d. STREET ADDRESS 4315 Raspe Avenue					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last CHARLES R. BEHRMANN						Month Day Year October 26 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 4, 1887		9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cutter				10b. KIND OF BUSINESS OR INDUSTRY Clothing Mfg. Co.				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Otto Behrmann						14. MOTHER'S MAIDEN NAME Rosina Lober					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes						16. SOCIAL SECURITY NO. 213-05-3196					
17. INFORMANT Clinical Records VAH, Fort Howard Division						Address Baltimore 18, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSTEROLATERAL MYOCARDIAL INFARCTION DUE TO (b) LEFT CORONARY ATHEROMATOUS OCCLUSION (c) PROSTATIC ADENOCARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XXXXX PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Bronchopneumonia, Right Lung. Operation 10/19/61-Transurethral Resection										INTERVAL BETWEEN ONSET AND DEATH 5 HOURS + UNKNOWN UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		20g. (County) Baltimore		
21. I certify that XX (this hospital) attended the deceased from October 11 1961 to October 26 1961 , that XX (we) last saw the deceased alive on Oct. 26 19 61 , and that death occurred at 1:25 AM , from the causes and on the date stated above.											
22a. SIGNATURE Sebastian Russo						22b. DATE SIGNED 10/26/61		22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.			
22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10-30-1961		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City, town or county) Baltimore		23e. (State) Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Edgar F. Lassehn						ADDRESS 7401 Belair Rd., Balto. Maryland		25a. REC'D BY REGISTRAR OCT 30 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Haines	

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Belmont

Port of New York

15 Days

Belmont

4115 Grand Avenue

Veterans Administration Hospital

CHAMBER

M.

Belmont

October 15

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October

October 15, 1957

U. S. A.

Ohio

Belmont

Belmont, Ohio, 10/15/57

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W. I.

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Belmont, Ohio, 10/15/57

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Belmont, Ohio, 10/15/57

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Belmont, Ohio, 10/15/57

11082

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11036

11026

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN R. BELL		4. DATE OF DEATH October 21 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 19, 1923
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aviation Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Dept. of Agriculture	11. BIRTHPLACE (County & State, or foreign country) Waynesboro, Penna.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Leroy C. Bell	
14. MOTHER'S MAIDEN NAME Elsie Stoops		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 11	
16. SOCIAL SECURITY NO. 215-12-7431		17. INFORMANT Clinical Records VA Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) NEPHROSCLEROSIS DUE TO (c) MALIGNANT HYPERTENSION		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 19 8:20 to Oct. 21 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 21, 1961 , and that death occurred at P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Elijah Saunders M.D.		22b. DATE SIGNED 10/22/61	
22c. PHYSICIAN'S NAME (Type) ELIJAH SAUNDERS, M. D.		22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIVISION	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/25/61	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HUBBARD Funeral Home		25a. REC'D BY REGISTRAR OCT 24 '61	
ADDRESS 4107 Wilkins Ave Balto. Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

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11037

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11027

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 28			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harlem Lodge				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle Edmund Last Lee				4. DATE OF DEATH Month OCT. Day 15 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-28-1906	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 15 Hours 15 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Funeral Supplies	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY? Baltimore, Md		13. FATHER'S NAME Robert E. L. Berger		14. MOTHER'S MAIDEN NAME Celine Bond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 2 240-10-3934		17. INFORMANT Mrs. R. E. L. Berger		Address 223 Garden Ridge Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Brain Tumor. Astrocytoma 193.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 29, 1960 to Oct. 15, 1961 that (I) (we) last saw the deceased alive on Oct. 14, 1961 , and that death occurred at 11:15 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Harry L. Knipp				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/16/61	
22c. PHYSICIAN'S NAME (Type) Harry L. Knipp, M. D.				22d. ADDRESS 4116 Edmondson Avenue Balto. 29, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-61		23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION (City, town, or county) (State) Ellicott City, Md	
24. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham				ADDRESS Ellicott City, Md		25a. REC'D BY REGISTRAR OCT 18 '61	
						25b. REGISTRAR'S SIGNATURE C. L. Knapp	

11037



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11038

11028

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 66yrs3dys d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3401-4 d. STREET ADDRESS 251 South Highland Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fredericka Middle Berkes Last			4. DATE OF DEATH Month October Day 11 Year 19 61				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Dec. 7, 1867			
9. AGE (In years last birthday) 93 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		11. BIRTHPLACE (County & State, or foreign country) Germany			
12. CITIZEN OF WHAT COUNTRY? Germany		13. FATHER'S NAME Peter Berkes		14. MOTHER'S MAIDEN NAME Anne Margaret Golderman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized arteriosclerosis (c) DUE TO (e), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 8, 1895 to Oct. 11, 1961 that (we) last saw the deceased alive on Oct. 11 19 61 and that death occurred at 3:10p. from the causes and on the date stated above.							
22a. SIGNATURE Stella Wachslar M.D. 22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 10-11-61 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 14, 1961		23c. NAME OF CEMETERY OR CREMATORY First United Evan. Cemetery			
23d. LOCATION (City, town or county) (State) Baltimore, Md.		24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.					
25a. REC'D BY REGISTRAR OCT 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11039

11029

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Forest Haven Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Fannie Middle Isabella Last Bieswanger				4. DATE OF DEATH Month October Day 26 Year 1961			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 4, 1886	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Dressmaker		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clarence Shelley				14. MOTHER'S MAIDEN NAME Isabella Godfrey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-07-8903		17. INFORMANT Lillian E. Morris		Address #28 1074 Craftswood Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Myocardia Conditions, if any, which gave rise to immediate cause (b) Diabetes Mellitus (a), stating the underlying cause last. (c) Arterio Sclerotic Cardiovascular PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Sclerosis						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 31, 1961 to Oct 26, 1961 , that (I) (we) last saw the deceased alive on Aug 26, 1961 , and that death occurred at 3 PM from the causes and on the date stated above.							
22a. SIGNATURE Paul M. Byerly, M.D.				22b. DATE SIGNED Oct 30 '61		22c. PHYSICIAN'S NAME (Type) Paul M. Byerly, M.D.	
22d. ADDRESS 5820 York Road							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/30/61		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				25a. REC'D BY REGISTRAR 4107 Wilkens Ave. #29		25b. REGISTRAR'S SIGNATURE Arthur S. K...	

(M)

Baltimore

Md.

Baltimore

Baltimore

Baltimore

Forest Haven Nursing Home

1074 Chestwood Rd.

xx

Female

Isabella

Isabella

October 20, 1911

Female white

x

Jan. 4, 1893

75 yrs.

Married

Dressmaker

Baltimore, Md.

U. S. A.

Clarence Shelley

Isabella Godfrey

2

216-07-8903 William B. Morris 1074 Chestwood Rd.

no

Paul M. Henry, M. D. 5820 York Road

Burial

10/30/51

Woodlawn Cemetery

Baltimore, Md.

Howard H. Hubbard 4107 Wilkens Ave. 4529

Oct 30 1951

11020

11020

(M)

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible] yrs.
SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

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CERTIFICATE OF DEATH

Reg. Dist. No.

11031

11041

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>177 Winters Ave.</u>				d. STREET ADDRESS <u>177 Winters Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Hattie E. Blackwell</u>				4. DATE OF DEATH <u>Oct - 7, 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1885</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR <u>5</u> Months		IF UNDER 24 HRS. <u>7</u> Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John H. Thorne</u>				14. MOTHER'S MARRIAGE NAME <u>Martha - unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Ada Webb - 177 Winters Ave, Catonsville Md.</u>			
17. INFORMANT <u>Ada Webb - 177 Winters Ave, Catonsville Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitral Insufficiency</u> DUE TO <u>442X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-Renal Disease</u> DUE TO (c) <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Oct. 1st, 1961</u> , to <u>Oct. 7th, 1961</u> , that I last saw the deceased alive on <u>Oct. 7th, 1961</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. F. Maloney, M.D.</u>				ADDRESS (Street, city or town, state) <u>57 Winters Lane Catonsville, 28. Md.</u>			
DATE SIGNED <u>10/7/61</u>							
PHYSICIAN'S NAME (Type) <u>C. F. Maloney, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/10/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Lanham Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Snowden</u>				ADDRESS <u>Rockville Md.</u>		24a. REC'D BY REGISTRAR <u>DATE OCT 13 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11042

11032

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in the Pines Convalescent Home</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>617 Colorado Avenue 10</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last <u>Pauline Dorothea Blome</u>				4. DATE OF DEATH Month Day Year <u>Oct. 8, 1961</u>													
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 1, 1886</u>		9. AGE (In years last birthday) <u>75</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Registered Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME <u>George S. Blome</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Stauff</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Miss Ann O. Blome</u> Address <u>617 Colorado Ave. Balto. 10</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>422.01</u> DUE TO (e), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>1032</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that (I) (the hospital) attended the deceased from <u>Sept. 23</u> , 1961, to <u>October 8</u> , 1961, that (I) (no) saw the deceased alive on <u>October 7</u> , 1961, and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.																	
22a. SIGNATURE <u>Wilmer K. Gallagher</u> M.D.				22b. DATE SIGNED <u>10/9/61</u>													
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>				22d. ADDRESS <u>6209 Friedrich Ave. Balt. 25, Md.</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Tinkertown</u>				25a. REC'D BY REGISTRAR <u>OCT 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hanna</u>											

11043

11043



1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

11043

11033

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 47 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westchester Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Christ ina Middle Agnes Last Blum		4. DATE OF DEATH Month Oct. Day 24 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1880
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min. 81	IF UNDER 24 HRS. Months 81 Days 81 Hours 81 Min. 81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Thomey		14. MOTHER'S MAIDEN NAME Elizabeth Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Lester H. Blum		Address Westchester Ave., Ellicott City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO 2 years			INTERVAL BETWEEN ONSET AND DEATH Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 10 1960 , to Oct 24 1961 , that (I) (we) last saw the deceased alive on Oct 23 1961 , and that death occurred 3 P M, from the causes and on the date stated above.			
22a. SIGNATURE William F. Gassaway		22b. DATE SIGNED 10/24/61	
22c. PHYSICIAN'S NAME (Type) William F. Gassaway		22d. ADDRESS Ellicott City, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/27/1961	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home		25a. REC'D BY REGISTRAR OCT 27 '61	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MEDICAL CERTIFICATION

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THE STATE
DEPARTMENT



12084

Baltimore

MD.

Baltimore

1000 Main Drive

8616 Towdrie Road

Baltimore

L.

Range

12/1/1963

August Chambers

James Bond

James W. Hollinger, Jr.

none

none

no

Forensic Examination

Investigative C. W. ...

Operator

Baltimore, Maryland

New Cathedral Cemetery

10/21/17

Baptist

Howard L. Hubbard 4107 Wilkins Avenue

CERTIFICATE OF DEATH

Reg. Dist. No. **11035**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home		d. STREET ADDRESS 3805 Cedar Dr.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SAMUEL Middle DAVID Last Bottom JR.		4. DATE OF DEATH Month Oct.13, Day 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1916
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months 45 Days 10 Hours 10 Min.	11. IF UNDER 24 HRS. Months 45 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent		10b. KIND OF BUSINESS OR INDUSTRY National Can Co. Cristfield, Md	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel D. Bottom Sr.		14. MOTHER'S MAIDEN NAME Eva Hart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 215-09-6044	
17. INFORMANT Betty Shunk Bottom		Address 3805 Cedar Dr. 7	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multifocal Sclerosis - severe DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 1, 1955 to OCT 13, 1961 , that I last saw the deceased alive on OCT 13, 1961 , and that death occurred at 9 A M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas E. Wheeler		ADDRESS (Street, city or town, state) Randallstown, Md	
PHYSICIAN'S NAME (Type) THOMAS E. WHEELER		DATE SIGNED 10/13/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-16-61	
22c. NAME OF CEMETERY OR CREMATORY Balto. National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		ADDRESS Pikesville, Md.	
24a. REC'D BY REGISTRAR DATE OCT 16 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Thoma	

1108

UNITED STATES OF AMERICA

1-062

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COLUMBIA

THE NEW YORK PUBLIC LIBRARY

ASTOR LENOX TILDEN FOUNDATION

125 WEST 47TH STREET, NEW YORK 19, N.Y.

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LIBRARY OF THE NEW YORK PUBLIC LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11046
CERTIFICATE OF DEATH
11036

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>Md.</u> c. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>149 Westminster Road</u>		d. STREET ADDRESS <u>149 Westminster Road</u>	
3. NAME OF DECEASED (Type or print) <u>Birdie</u> First <u>Louise</u> Middle <u>Broadfoot</u> Last		4. DATE OF DEATH Month <u>Oct.</u> Day <u>23</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles King</u>		14. MOTHER'S MAIDEN NAME <u>Susannah Stone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Louise B. Chaney</u>		Address <u>Reisterstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 mins.</u> <u> </u> years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 1, 1952</u> to <u>October 23, 1961</u> that (I) (we) last saw the deceased alive on <u>October 20, 1961</u> , and that death occurred at <u>11A</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Martin E. Strobel</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>		22b. DATE SIGNED <u>10-23-61</u>	
22d. ADDRESS <u>48 Main Street, Reisterstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 26, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Pikesville Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Eline & Sons</u>		ADDRESS <u>Reisterstown, Md.</u>	
25a. REC'D BY REGISTRAR <u>OCT 25 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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October 1, 1952

October 1, 1952

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.

Very truly yours,

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11047

11037

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1349 W. North Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) HUBERT A. BROOKS				4. DATE OF DEATH Month October Day 10 Year 19 61								
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 4, 1900		9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer				10b. KIND OF BUSINESS OR INDUSTRY Photography		11. BIRTHPLACE (County & State, or foreign country) Ocala, Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Anderson Brooks				14. MOTHER'S MAIDEN NAME Violet Reed								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WWI				16. SOCIAL SECURITY NO. 267-38-8788				17. INFORMANT Clin. Records, VA Hospital Balto 18, Md. Fort Howard Division				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 420.1 (b) ARTERIOSCLEROTIC HEART DISEASE (c) DIABETES MELLITUS								INTERVAL BETWEEN ONSET AND DEATH 4 DAYS UNKNOWN UNKNOWN				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CYSTITIS. CHRONIC PYELONEPHRITIS WITH UREMIA								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that HD (this hospital) attended the deceased from OCTOBER 8, 19 61 , to OCTOBER 10, 19 61 that it (we) last saw the deceased alive on October 10, 19 61 , and that death occurred 11:55AM from the causes and on the date stated above.												
22a. SIGNATURE F. S. Donaldson , M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 10/10/61			
22c. PHYSICIAN'S NAME (Type) F. S. DONALDSON, M.D.						22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIVISION						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 10-16-61		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL			23d. LOCATION (City, town or county) BALTIMORE 28, MARYLAND			(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law						25a. REC'D BY REGISTRAR OCT 13 '61			25b. REGISTRAR'S SIGNATURE Clifford S. Hume			
Charles R. Law Funeral Home, 802 Madison Ave., Baltimore, Md.												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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CERTIFICATE OF DEATH

Reg. Dist. No.

11038

11048

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville.,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville.,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 104 A Winters Lane.,				d. STREET ADDRESS 104 A Winters Lane.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle BROWN Last BROWN				4. DATE OF DEATH Month OCT. Day 19, Year 1961			
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1885		9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Isaih Brown				14. MOTHER'S MAIDEN NAME Laura Nugent			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Sadie Brown: Item # 2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma (Intestinal) I yr 4 Months 4 Days 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 17th., 1960, to Oct. 19th, 1961, that I last saw the deceased alive on Oct. 19th, 1961, and that death occurred at 2.00AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED C.F. Maloney M.D. 57 Winters Lane 10/19/61							
ACTUAL SIGNATURE C.F. Maloney M.D.		PHYSICIAN'S NAME (Type) C.F. Maloney, M.D. Catonsville, 28. Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/61		22c. NAME OF CEMETERY OR CREMATORY Western Star,		22d. LOCATION (City, town, or county) (State) Catonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden, ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR DATE OCT 24 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

25011

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11049

11039

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7(Rockdale)				c. LENGTH OF STAY IN 1b 7 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3662 Clifmar Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sia Middle Paul Last Brown				4. DATE OF DEATH Month October Day 23 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15, 1909	
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY General Baking Co.			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jacob Brown				14. MOTHER'S MAIDEN NAME Cecelia Combs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 212-03-3588			
17. INFORMANT Mrs. Ellen C. Brown, 3662 Clifmar Road, Baltimore 7, Maryland				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR STAND STILL 420.1 DUE TO COMPLETE HEART BLOCK Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) CORONARY SCLEROSIS DUE TO (c) CORONARY SCLEROSIS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JANUARY 1961 to OCTOBER 1961 , that (I) (we) last saw the deceased alive on OCTOBER 23 1961 , and that death occurred at 3:20 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Samuel P. Scalia				22b. DATE SIGNED 10-25-61			
22c. PHYSICIAN'S NAME (Type) Dr. Samuel P. Scalia				22d. ADDRESS 1331 Reisterstown Rd, Pikesville 8, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10/26/61			
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery				23d. LOCATION (City, town, or county) (State) Baltimore Maryland			
24a. FUNERAL DIRECTOR'S SIGNATURE Living Byers				24b. ADDRESS 8728 Liberty Road Randallstown, Md.			
25a. REC'D BY REGISTRAR 26 OCT 26 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11050

CERTIFICATE OF DEATH

11040

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u> c. LENGTH OF STAY IN lb. <u>2 mos</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prettyboy Dam Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u> d. STREET ADDRESS <u>Prettyboy Dam Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Stanley Guy Brown</u> First Middle Last				DATE OF DEATH <u>October 4, 1961</u> Month Day Year							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 30, 1898</u> Yrs. Months Days		9. AGE (In years last birthday) <u>62</u> IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Ellicott City, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George B. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Grace Keene</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>213-013217</u>				17. INFORMANT <u>Mrs. Mildred Brown, Parkton, Md. R.D.</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____		(County) _____		(State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1961</u> to <u>Oct. 4, 1961</u> , that (I) <u>was</u> last saw the deceased alive on <u>Oct. 3, 1961</u> , and that death occurred at <u>8:55 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>A. M. France</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/6/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>						22d. ADDRESS <u>PARKTON, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Oct. 7-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>				23d. LOCATION (City, town or county) <u>Parkton, Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Knecht</u>			
DATE <u>OCT 10 '61</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11051
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11041
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, Md. d. STREET ADDRESS 518 Franklin St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Hughes Middle England Last Burlin				4. DATE OF DEATH Month Oct. Day 20 Year 19 61			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1879	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Laborer		10b. KIND OF BUSINESS OR INDUSTRY Day		11. BIRTHPLACE (State or foreign country) Unknown Md.		12. CITIZEN OF WHAT COUNTRY? Unknown/U.S.A.	
13. FATHER'S NAME Unknown Samuel O. Burlin				14. MOTHER'S MAIDEN NAME Unknown Mary A. Carroll			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No Unknown				17. INFORMANT Address Records: Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.9 Acute cardiac failure DUE TO (b) Intestinal Malignancy (Carcinoma) DUE TO (c) Generalized Arterio Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE George M. Kieffer M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) George M. Kieffer, M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1010 Lead... DATE SIGNED 10/20/61 Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-1961		22c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		22d. LOCATION (City, town, or country) (State) Port Deposit, Md. Rural	
23. FUNERAL DIRECTOR ADDRESS See Ad. Peterson & Son Perryville, Md.				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE ...	

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WILLIAM A. GIBSON

WILLIAM A. GIBSON

1900-01-01

1900-01-01

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
11052					11042					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Baltimore					e. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 1411 Montgomery Road					
3. NAME OF DECEASED (Type or print) LUTHER F. BUTTS					4. DATE OF DEATH Month October Day 11 Year 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1930		9. AGE (In years last birthday) 31 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Houses		11. BIRTHPLACE (County & State, or foreign country) McGehee, Arkansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13. FATHER'S NAME Frank Butts					14. MOTHER'S MAIDEN NAME Lillie McKenny					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 429-52-0962					
17. INFORMANT Clinical Records VAH, FORT HOWARD DIVISION					Address Baltimore 18, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH 1 Day		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACRANIAL BLEEDING DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ANEURISM OF INTERNAL CAROTID ARTERY, LEFT, CONGENITAL DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		20g. (County) Baltimore		
20h. (State) Md.		20i. (City or town) Baltimore		20j. (County) Baltimore		20k. (State) Md.		20l. (City or town) Baltimore		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 11, 1961 to October 11, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 11, 1961 , and that death occurred at P.M. from the causes and on the date stated above.										
22a. SIGNATURE Thomas F. Crahan					22b. DATE 10/12/61					
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.					22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/16/61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore		23d. LOCATION (City, town or county) (State) 28, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home					25a. REC'D BY REGISTRAR 3331 Abrams Lane 2601 E. Madison, Balto. Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE OCT 13 '61	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11053

11043

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 6 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 705 Westover Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT O. BUTTS		4. DATE OF DEATH October 5 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 1, 1894 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wine Steward		10b. KIND OF BUSINESS OR INDUSTRY Club	11. BIRTHPLACE (Country & State, or foreign country) Woodstock, Maryland
13. FATHER'S NAME Arthur U. Butts		14. MOTHER'S MAIDEN NAME Mary E. Everhart	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-1		17. INFORMANT Clin Rec VAH Baltimore Md-Ft Howard Division	
16. SOCIAL SECURITY NO. 218-03-5332		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS OF LEFT MIDDLE CEREBRAL ARTERY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS, GENERAL DUE TO (c) UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Emphysema of Lungs; Arteriosclerotic Heart Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 29 19 61 to Oct. 5 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 5 19 61 , and that death occurred at 3:35 p.m. from the causes and on the date stated above.			
22a. SIGNATURE John W. Pemberton M.D.		22b. DATE SIGNED 10-5-61	
22c. PHYSICIAN'S NAME (Type) John W. Pemberton		22d. ADDRESS VAH Baltimore Md - Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-9-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc		25a. REC'D BY REGISTRAR OCT 10 '61	
25b. REGISTRAR'S SIGNATURE Charles L. House			

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TO HO... MAY BE... TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11054

11044

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex 21		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex 21	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1713 Ann Ave.		d. STREET ADDRESS 1713 Ann Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Guy Alton Calligan Sr.		4. DATE OF DEATH Month Day Year October 29 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 13, 1894
9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Calligan		14. MOTHER'S MAIDEN NAME Mary Elizabeth Abbott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-2570	
17. INFORMANT Anna Elizabeth Calligan		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/15/61 to 10/29/61 , 19 61 , that (I) was lost saw the deceased alive on 10/29 19 61 , and that death occurred on 10/29 A.M., from the causes and on the date stated above.			
22a. SIGNATURE Robert J. Lyden		22b. DATE SIGNED 10/30/61	
22c. PHYSICIAN'S NAME (Type) ROBERT J. LYDEN		22d. ADDRESS 815 EASTERN AVE BALT 2 MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/1/61	
23c. NAME OF CEMETERY OR CREMATORY Belair Memorial Gardens		23d. LOCATION (City, town, or county) (State) Belair, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE James E. Bruzdinski		25a. REC'D BY REGISTRAR DET 31 '61	
ADDRESS 1407 Eastern Ave.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11045

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>—</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3621 EITEMILLER RD BALT</u>		c. LENGTH OF STAY IN 1b <u>6 MOS.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		V01-4	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>4316 BELAIR RD - 6</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>EDWARD</u> Last <u>CHARLTON</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 26 - 1886</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ENGINEERING</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES CHARLTON</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS DOLORES SCHLIPPER - 3621 EITEMILLER RD</u>		Address <u>BALTO 7-MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C.V. disease and</u> DUE TO (c) <u>insufficiency.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>APRIL 1</u> , 19 <u>61</u> , to <u>OCT 18</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>OCT 18</u> , 19 <u>61</u> , and that death occurred at <u>5 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u> M.D.		ADDRESS (Street, city or town, state) <u>Randallstown Md</u> DATE SIGNED <u>10-18-61</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/21/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PARKVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME</u> ADDRESS <u>4220 BELAIR RD</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 20 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MARYLAND STATE DEPARTMENT OF THE ARMY - BALTIMORE 11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11048

11055

1. PLACE OF DEATH a. COUNTY <i>Baltimore 20</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Baltimore 21</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTO.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTO. 21</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>IVY HALL NURSING HOME</i>				d. STREET ADDRESS <i>1011 ARN CLIFF RD.</i>			
3. NAME OF DECEASED (Type or print) <i>Helen E. Church</i>				4. DATE OF DEATH <i>Oct 27 1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 21, 1886</i>	
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>RUMANIA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>?</i>				14. MOTHER'S MAIDEN NAME <i>RAUSCH UNKNOWN</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>-</i>			
17. INFORMANT <i>HENRY F. BECKER</i>				Address <i>8628 OAKLEIGH RD.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Apoplexy -</i>						<i>8 days</i>	
334X DUE TO <i>Hypertension and arteriosclerosis</i>						<i>5 years.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>April 15, 1959</i> to <i>Oct 27, 1961</i> , that I last saw the deceased alive on <i>Oct 23, 1961</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Henry F. Becker</i>				ADDRESS (Street, city or town, state) <i>901 Fuselage Dr Baltimore 20 Md</i>			
DATE SIGNED <i>Oct 25, 1961</i>							
PHYSICIAN'S NAME (Type) <i>IRVING R. BECK M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>10-26-61</i>		22c. NAME OF CEMETERY OR CREMATORY <i>GARDENS OF FAITH</i>		22d. LOCATION (City, town, or county) (State) <i>BALTO. CO. MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H.W. JENKINS & SONS Co.</i>				ADDRESS <i>4905 YORK ROAD</i>			
24a. REC'D BY REGISTRAR <i>Oct 25, 1961</i>				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11057

11047

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 32 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30 d. STREET ADDRESS 817 West Ostend Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPH W. CLARK				4. DATE OF DEATH October 27 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 19, 1896	
9. AGE (In years test birthday) 65 yrs.		10. USUAL OCCUPATION (Give time of work done during most of working life, even if retired) Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY Public Building		11. BIRTHPLACE (County & State, or foreign country) Max Meadows, Virginia	
13. FATHER'S NAME Austin Clerk				14. MOTHER'S MAIDEN NAME Alice Grogans			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW I				16. SOCIAL SECURITY NO. 216-01-3205			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH WITH METASTASIS TO ABDOMINAL ORGANS DUE TO 151X Conditions, if any, which gave rise to immediate cause (b) 151X DUE TO 151X (a), stating the underlying cause last. (c) 151X				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation-10/3/61 Exploratory Laparotomy, gastroenterostomy							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from September 25, 1961 , to October 27, 1961 that (X) (we) last saw the deceased alive on October 27, 1961 , and that death occurred at A. M. from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. Crahan				22b. DATE 10/27/61			
22c. PHYSICIAN'S NAME (Type or print) THOMAS F. CRAHAN, M.D.				22d. ADDRESS VAH, BALTO. 18 MD., FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/31/61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Charles A. Rice				25a. REC'D BY REGISTRAR OCT 30 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

1100

1100

(M)

Delivered

To: Mr. Tolson

cc: Mr. Boardman

cc: Mr. Nichols

Very truly yours,

John Edgar Hoover

John

Hoover

October 27

1951

Mr. Tolson

Mr. Boardman

cc:

Stationary Division

Public Building

Box 10000, Virginia

U. S. A.

Amelia Gentry

Miss Gentry

Mr. Tolson

cc:

Mr. Boardman

Mr. Nichols

Mr. Boardman

Mr. Nichols

Operation 10/3/51

September 27

October 27

cc:

Mr. Boardman

Mr. Nichols

Mr. Tolson

Mr. Boardman

October 27

Mr. Boardman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 13 mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PHILIP KING CLARKE		4. DATE OF DEATH Month 10 Day 31 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10.3.1889
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 10 Days 31 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Retired policeman		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PHILIP M. CLARKE		14. MOTHER'S MAIDEN NAME AGNES TUCKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Far advanced pulmonary tuberculosis DUE TO 4 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) lois DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus. Uremia		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9.30 19 60 to 10.31 19 61 , that (I) (we) last saw the deceased alive on 10.31 19 61 , and that death occurred at 10.20 am the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 10.31.1961	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/2/61	
23c. NAME OF CEMETERY OR CREMATORY St. Aloysius		23d. LOCATION (City, town, or county) (State) Leonardtown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. H. Hattley		25a. REC'D BY REGISTRAR NOV 2 '61	
ADDRESS Leonardtown, Md		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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(M)

Mr. James H. King

13 mo 2nd 1964

4623 2nd Ave

CLARK KING

X 10 3 1888 75

10 31 61

ANNE S. CLARK

For a copy of the report of the

Commissioner of the

State of New York

for the year 1964

see page 10 of the

report of the

Commissioner of the

State of New York

for the year 1964

see page 10 of the

report of the

Commissioner of the

State of New York

for the year 1964

see page 10 of the

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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18, Form Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11059 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
11049											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b 10 Months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Res., 855 Loalan Avenue						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester d. STREET ADDRESS Chester, Maryland e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MARY Middle CLARA Last CIENDANIEL						4. DATE OF DEATH Month October Day 16 Year 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1873		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 17 Days 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Franklin Lewis						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Edw. Staab Address 855 Loalan Ave. 22, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. Senility DUE TO (b) Senility (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 10/17/61											
ACTUAL SIGNATURE Melvin B. Davis				M.D. Melvin B. Davis, M.D.				DATE SIGNED 10/17/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-19-1961		22c. NAME OF CEMETERY OR CREMATORY Stevensville		22d. LOCATION (City, town, or county) (State) Stevensville, Maryland					
23. FUNERAL DIRECTOR Lane Funeral Home Church Hill, Md. ADDRESS						24a. REC'D BY REGISTRAR OCT 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Klaus			

Arthur S. Klaus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11050											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN 1b 26 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 36 Bosley Avenue						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS 36 Bosley Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William Marshall Cook						4. DATE OF DEATH October 22, 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 23, 1896		9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lineman				10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co.				11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marshall P. Cook						14. MOTHER'S MAIDEN NAME Florence Dove					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-05-9023		17. INFORMANT Mrs. Augusta B. Cook Address Reisterstown, Md. 36 Bosley Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Congestive Heart Failure - Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Arteriosclerosis - generalized INTERVAL BETWEEN ONSET AND DEATH Instant 2 years years											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 1953 to October 21, 1961 , that (I) (we) last saw the deceased alive on October 15, 1961 , and that death occurred at 10 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Clarence E. McWilliams M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED October 23, 1961			
22c. PHYSICIAN'S NAME (Type) Clarence E. McWilliams M.D.						22d. ADDRESS 1904 Reisterstown Rd. Reisterstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 25, 1961		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens				23d. LOCATION (City, town or county) (State) Finksburg, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Henry James Eckhardt ADDRESS Owings Mills, Md.						25a. REC'D BY REGISTRAR OCT 25 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11061

CERTIFICATE OF DEATH

11051

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> c. LENGTH OF STAY IN 1b <u>5 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>(at his residence--1824 Vista Lane)</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u> d. STREET ADDRESS <u>1824 Vista Lane.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>William Franklin Crawford</u>		4. DATE OF DEATH Month <u>October</u> Day <u>22</u> Year <u>1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July-1-1898</u>		9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Cans</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>CLINTON LEE CRAWFORD</u>						14. MOTHER'S MAIDEN NAME <u>MINNIE M. McMackin</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>215-05-2007</u>						17. INFORMANT Address <u>Mrs Edith G. Crawford (wife) 1824 Vista Lane.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emphysema</u> 502.0 DUE TO <u>Chronic bronchitis</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>4 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>									
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Nov 19 61</u> to <u>Oct 22 61</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Oct 19 61</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>William F. Fritz</u>						ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/25/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM F. FRITZ MD.</u>						22d. ADDRESS <u>20 University Parkway</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				23b. DATE THEREOF <u>Oct-25-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GreenMount</u>				23d. LOCATION (City, town or county) <u>Baltimore City 2, Md.</u>					
24 FUNERAL DIRECTOR'S SIGNATURE <u>Stewart & Mowen Co. 108-W-North-Av, Balto. 1, Md</u>						25a. REC'D BY REGISTRAR <u>DATE OCT 24 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

0036011

0036011

M

CERTIFICATE OF DEATH

Reg. Dist. No. 11052

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Washington, D.C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural: Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood Sanatorium Towson 4, Maryland		d. STREET ADDRESS 3120 Wisconsin Ave	
3. NAME OF DECEASED (Type or print) First Georgena Middle H. CRENshaw Last 10 29 1961		4. DATE OF DEATH Month 10 Day 29 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-30-1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 78 yrs.
13. FATHER'S NAME George R. UPTON		14. MOTHER'S MAIDEN NAME Isabella Hartford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS DUE TO 21 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIO SCLEROTIC HEART DISEASE			INTERVAL BETWEEN ONSET AND DEATH 21 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-23 , 19 61 , to 10-29 , 19 61 , that I last saw the deceased alive on 10-29 , 19 61 , and that death occurred at 1:15a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Milton B. Kline M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 10-30-1961	22c. NAME OF CEMETERY OR CREMATORY Magnolia Cemetery	22d. LOCATION (City, town, or county) (State) Greenville, Ala.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Stanley		24a. REC'D BY REGISTRAR DATE OCT 31 '61	24b. REGISTRAR'S SIGNATURE William B. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11000

CERTIFICATE OF DEATH

11000

M

1



11053

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/60

M

ON

Elaine Davis

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26.04.17 14.05.17

8340 Old Glenview Rd

8501

39011

12/19/11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11064
11054
MAYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MAYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anne Arundel Co	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS Quarterfield Rd, 02x-1	
3. NAME OF DECEASED (Type or print) First Albert Middle Frederick Last Reichgrabe		4. DATE OF DEATH Month 10 Day 30 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-1896
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR Months 6 Days 5 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laboret		10b. KIND OF BUSINESS OR INDUSTRY Plastic	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Reichgrabe		14. MOTHER'S MAIDEN NAME Louise Schoning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-03-0022	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 163X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tuberculosis of the Lungs 002X		INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/31 19 60 , to 10/30 19 61 , that (I) (we) last saw the deceased alive on 10/30 19 61 , and that death occurred at 10/30 M, from the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 10/30/61	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 31 Nov. 61	
23c. NAME OF CEMETERY OR CREMATORY Glenn Burnie		23d. LOCATION (City, town, or county) (State) Glenn Burnie Md.	
24. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton		25a. REC'D BY REGISTRAR Glenn Burnie, Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE NOV 6 '61	

11002

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
OFFICE OF THE ASSISTANT ATTORNEY GENERAL
DIVISION OF VITAL RECORDS
CERTIFICATE OF DEATH

11002

(M)

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the document]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

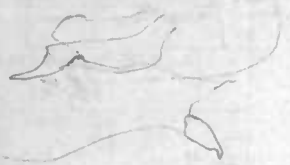
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 309 3-22-62											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
11065 CERTIFICATE OF DEATH 11055											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>			c. LENGTH OF STAY IN 1b <u>5 mo. 21 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville 1651-2</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>					d. STREET ADDRESS <u>2025 Roanoke St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>Libbey</u> Last <u>Delehanty</u>					4. DATE OF DEATH Month <u>10</u> Day <u>2</u> Year <u>1961</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/21/07</u>		9. AGE (In years last birthday) <u>54</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Edward W. Libbey</u>					14. MOTHER'S MAIDEN NAME <u>Edith Hoffman</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-4983</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(a) Far Advanced Pulmonary Tuberculosis (10 mo)</u> <u>(b) Cor Pulmonale</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>(c) Emphysema</u> DUE TO <u>Part II Bronchial Asthma</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u> <u>?</u> <u>20 yrs.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 FAY / 1 A / 1 K / 1 L / 1 M / 1 N / 1 O / 1 P / 1 Q / 1 R / 1 S / 1 T / 1 U / 1 V / 1 W / 1 X / 1 Y / 1 Z</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>4/11</u> 19 <u>61</u> to <u>10/2</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/2</u> 19 <u>61</u> , and that death occurred at <u>10:35 A.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Wm. Newcomer</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/2/61</u>				
22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u>					22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>10-4-61</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem</u>		23d. LOCATION (City, town, or county) (State) <u>COLUMBIA MANOR Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Tim See & Sons</u>					ADDRESS <u>300 Hille St NE</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		

11007

11007

11007



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11066
CERTIFICATE OF DEATH
11056

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in The Pines		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Irene First Desi Middle Last		4. DATE OF DEATH October 17 19 61 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 27, 1886
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Martin Lichtenstein		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. George Desi- Address 300 Eva Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Decomensation 422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Atherosclerotic Cardio Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) marked microcytic anemia			INTERVAL BETWEEN ONSET AND DEATH 7da 103r
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1960 to Oct 17, 1961 , that (I) (we) last saw the deceased alive on 10-17 19 61 , and that death occurred at 4P M, from the causes and on the date stated above.			
22a. SIGNATURE Wilmer K. Gallagher		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wilmer K. Gallagher M.D.		22d. ADDRESS 6209 Frederick Ave Balt. 28, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF Oct 18/61	23c. NAME OF CEMETERY OR CREMATORY Riverside	23d. LOCATION (City, town, or county) (State) New York
24. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc. 6010 Reist Road		25a. REC'D BY REGISTRAR OCT 23 '61 DATE	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1106

CERTIFICATE OF DEATH

1106

Name of Deceased		Date of Death	
Age		Sex	
Place of Birth		Usual Residence	
Cause of Death		Occupation	
Signature of Physician		Signature of Registrar	
Date		Place	

Attest my hand and the seal of the Health Department this _____ day of _____, 19____.

Registrar

Health Department

1990

CERTIFICATE OF DEATH

Reg. Dist. No.

11058

11068

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>3 V 014</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Agel Thomas + Agel Maus Home</u>		d. STREET ADDRESS <u>3257 Chestnut Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>May</u> Last <u>Dwyer</u>		4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28, 1866</u>
9. AGE (In years last birthday) <u>95</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dressmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Dwyer</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Coomes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Daisy E. Hammett</u>		Address <u>615 Chestnut Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>442x</u> DUE TO <u>Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>Arteriosclerotic Cardio-Renal Disease</u> (c) <u>3 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> to <u>October 15, 1961</u> , that I last saw the deceased alive on <u>October 13, 1961</u> , and that death occurred at <u>3:30 a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Newland E. Day</u>		ADDRESS (Street, city or town, state) <u>4 East 33rd St Balto.</u> DATE SIGNED <u>October 16, 1961</u>	
PHYSICIAN'S NAME (Type) <u>Newland E. Day, M.D.</u>		<u>4 East 33rd Street, Baltimore 18</u>	
22a. BURIAL, CREMATION, or other disposition (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>10-17-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Hampden, Baltimore</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street, ZONE 2</u>		24a. REC'D BY REGISTRAR <u>OCT 18 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawe</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1940-1941

10540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11069

CERTIFICATE OF DEATH

11059

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ridgeway Manor Nursing Home				d. STREET ADDRESS 76 River Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary E. Eagle				4. DATE OF DEATH Oct. 10 19 61					
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/1881		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (County & State, or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Rufus N. Wathall				14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Rosalie Baacke, step-daughter, 613 Brookwood Rd Zone 29 Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC CV DISEASE. PARKINSON'S DISEASE.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-27 1961 , to 10-10 1961 , that (I) (was) last saw the deceased alive on 10-6 1961 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.									
22a. SIGNATURE John F. Schaefer M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/11/61			
22c. PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER				22d. ADDRESS 401 RANDOM ROAD-29					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/12/61		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek 3331 Brehms Lane				25a. REC'D BY REGISTRAR OCT 13 '61		25b. REGISTRAR'S SIGNATURE Charles E. Schimunek			

11003



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11070

CERTIFICATE OF DEATH

Reg. Dist. No.

11060

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Halethorpe, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>15624 Carville Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>C.</u> Last <u>Earehart</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>6</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20, 1906</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Dwyer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Woosley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-4836</u>	
17. INFORMANT <u>Paul Earehart</u>		Address <u>5624 Carville Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X Mitral Stenosis</u>			
DUE TO (b) <u>Rheumatic heart disease.</u>			
DUE TO (c) <u>Hypertension</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>Aug</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>61</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Lomas</u>		ADDRESS (Street, city or town, state) <u>910 W. Lombard St Balt 23 Md</u>	
PHYSICIAN'S NAME (Type) <u>Oct 8/1961</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 10-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Isabel Perry</u>		ADDRESS <u>5646 Carville Ave.</u>	
24a. REC'D BY REGISTRAR <u>Oct 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11071

11061



NAME: WHITE, ALBERT M.
 BIRTH: 1-1-01
 PLACE OF BIRTH: GEORGIA, U.S.A.
 NO. 11071
 CARD NO. 11071
 SECTION: 11071
 DATE OF BIRTH: 1-1-01
 PLACE OF BIRTH: GEORGIA, U.S.A.
 NO. 11071

11071

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11072

CERTIFICATE OF DEATH

11062

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN TB 31 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY - c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 426 E. Eager Street - 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROBERT L. EDWARDS		4. DATE OF DEATH October 14 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1919
9. AGE (In years last birthday) 42 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. BIRTHPLACE (County & State, or foreign country) Pinola, Miss.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John D. Edwards	
14. MOTHER'S MAIDEN NAME Rose Thompson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-11	
16. SOCIAL SECURITY NO. 213-28-2676		17. INFORMANT Clinical Records, VA Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (b) HYPERTENSIVE CARDIOVASCULAR DISEASE (e), stating the underlying cause last. (c) UNKNOWN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LAENNEC'S CIRRHOSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 13, 1961 to Oct. 14, 1961 that (X) (we) last saw the deceased alive on Oct. 14, 1961 , and that death occurred at 11:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Ralph N. Lee		22b. DATE SIGNED 10-15-61	
22c. PHYSICIAN'S NAME (Type) RALPH N. LEE M.D.		22d. ADDRESS VAH, Baltimore 18, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson		25a. REC'D BY REGISTRAR OCT 24 '61	
25b. REGISTRAR'S SIGNATURE Balto 17, Md.		25c. REGISTRAR'S SIGNATURE Arthur S. Kraus	

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **11063**

11073

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Towson</u>			c. LENGTH OF STAY IN 1b <u>X Rural Towson</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Villa Maria - Notch Cliff</u>				d. STREET ADDRESS <u>1 Glenarm, Maryland</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sister M. Joan of Arc (Ehmann)</u>				4. DATE OF DEATH Month Day Year <u>10 21 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Aug. 20, 1883</u>		9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>			
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>				13. FATHER'S NAME <u>John Ehmann</u>			
14. MOTHER'S MAIDEN NAME <u>Anna M. Schinerbach</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Sr.M. Henrica Villa Maria, Glenarm, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4-4-2 X</u> IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Artirio-schlerotic vascular renal disease</u> (b) <u>Arterial sclerotic</u> DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>November 19 45</u> to <u>October 19 61</u> , that I last saw the deceased alive on <u>Oct. 19 61</u> , and that death occurred at <u>10:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. Charles F. O'Donnell</u> <u>7501 York Road Towson 4, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-24-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>			
22d. LOCATION (City, town, or county) (State) <u>NOTCHCLIFF NR TOWSON, MD.</u>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Charles L. Seiler 901 S. CONRLING ST. BALTO., 24, MD.</u>					
24a. REC'D BY REGISTRAR <u>OCT 26 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Housh</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11074

11064

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 44 A Chapel Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u> d. STREET ADDRESS <u>Box 44 A Chapel Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anna Jane Eller</u>		4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1961</u>		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>10-4-1902</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife and saleslady</u> 10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Grady Merrell</u> 14. MOTHER'S MAIDEN NAME <u>Martha F. Edwards</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u> </u> 16. SOCIAL SECURITY NO. <u>215346818</u> 17. INFORMANT <u>Joseph B. Eller</u> Address <u>3712 Parkside Drive</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>199X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Abdominal Carcinoma</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 to 10 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u>, <u>1961</u> to <u>Oct 1</u>, <u>1961</u> , that (I) (we) last saw the deceased alive on <u>Sept 13</u>, <u>1961</u> , and that death occurred at <u>8:30</u> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Theodore E. Evans</u> M.D.				22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>Theodore E. Evans, M. D.</u> 22d. ADDRESS <u>9660 Belair Rd. Balto 6, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>10-3-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>			
23d. LOCATION (City, town or county) <u>Baltimore, Md.</u> (State) <u> </u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Rd.</u>					
25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> DATE <u>OCT 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

11004

11004

4

General and Special Agents
Department of Agriculture
Washington, D. C.

THEODORE H. ...
...

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11075

11065

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham 1866-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				d. STREET ADDRESS <u>6430 Auburn Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Olive</u> Last <u>Ericson</u>				4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/23/1897</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Translator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>IOWA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles W. Ericson</u>				14. MOTHER'S MAIDEN NAME <u>Melisa O. Barnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>Hospital Records, Mt. Wilson State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Oedema</u> <u>420-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs</u> <u>11 hr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Far Advanced Pulmonary Tuberculosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>002X</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/19</u> 19 <u>61</u> , to <u>10/9</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/9</u> 19 <u>61</u> , and that death occurred on <u>9A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. Newcomer</u>				22b. DATE <u>Oct 9, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>Wm. Newcomer, M.D. Superintendent</u>	
22d. ADDRESS <u>Mt. Wilson State Hospital, Mt. Wilson, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a. RECEIVED BY REGISTRAR <u>Oct 11 1961</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

11066

11076

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY BALTO.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			c. LENGTH OF STAY IN 1b 5 WKS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CATON RIDGE NURS. HOME			d. STREET ADDRESS 4431 OLD FREDERICK RD.		
3. NAME OF DECEASED (Type or print) CLAUDE W. FARRAR			4. DATE OF DEATH Month OCT. Day 9 , Year 1961		
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 24, 1902		9. AGE (In years last birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER, LOUDON PK. CEMTY.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM FARRAR			14. MOTHER'S MAIDEN NAME MINNIE MALLORY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 223-09-1513	17. INFORMANT MRS RUBY PEETZ, 4431 OLD FREDERICK RD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma Left Lung and Metastases. 162 Conditions, if any, which gave rise to immediate cause (b) 162 (c) 162 DUE TO 162 DUE TO 162 DUE TO 162					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/1 , 19 61 , to 10/11 , 19 61 , that (I) (we) last saw the deceased alive on 10/10 , 19 61 , and that death occurred at 11 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Charles A. Cahn			22b. DATE SIGNED 10/11-61		
22c. PHYSICIAN'S NAME (Type) Charles A. Cahn			22d. ADDRESS 2145 W. Baltimore St		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/12/61	23c. NAME OF CEMETERY OR CREMATORY WESTERN CEMTY.	23d. LOCATION (City, town or county) (State) BALTO. MD.		
24. FUNERAL DIRECTOR'S SIGNATURE WITZKE F. DR.			25. REC'D BY REGISTRAR 16 '61		
ADDRESS 4101 EDMONDSON AVE			25b. REGISTRAR'S SIGNATURE Arthur S. Hume		

MEDICAL CERTIFICATION

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11077

11067

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ST. JOSEPH'S NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>—</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>4222 VERMONT AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MARY AGNES FEDERLINE</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>27</u> Year <u>1961</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>May 5, 1881</u>		9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. PLACE OF BIRTH (Country & State, or foreign country) <u>Ind.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>JOHN MULCAHY</u> 14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give word and date of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Wm. P. Federline - 4222 Vermont Ave.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic cardiovascular disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>April 1961</u> to <u>Oct 27 1961</u> that (I) (we) last saw the deceased alive on <u>Oct 24 1961</u> and that death occurred at <u>1A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>James E. Rowe</u> M.D.						22b. DATE SIGNED <u>10/29/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>JAMES E. ROWE</u>						22d. ADDRESS <u>1011 Frederick Rd #28</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10-30-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Balto.</u> <u>Ind.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Twiley-Corraney L. F.H. - Catonsville, Md.</u> ADDRESS <u>—</u>											
25a. REC'D BY REGISTRAR DATE <u>NOV 6 '61</u>						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

11087

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(1)

James E. Lowe
1011 F. Avenue
St. Louis, Mo.
Sept. 10, 1911

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11078

11068

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY in 1b 45 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 318 Park Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LAWRENCE FITZGERALD First Middle Last		4. DATE OF DEATH October 13 1961 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1895 Yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (County & State, or foreign country) Albemarle Co Virginia	
10b. KIND OF BUSINESS OR INDUSTRY Automobile		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Fitzgerald		14. MOTHER'S MAIDEN NAME Sarah Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) Yes WW-1		16. SOCIAL SECURITY NO. 219-01-0014	
17. INFORMANT Clin Rec VAH Baltimore Md Ft Howard Division		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) CA OF PANCREAS (c) BILIARY CIRRHOSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemorrhagic Cystitis INTERVAL BETWEEN ONSET AND DEATH 6-7 days Unknown Unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 29 1961 , to Oct 13 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct 13 1961 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Arthur T. Faulk		22b. DATE SIGNED 10-14-61	
22c. PHYSICIAN'S NAME (Type) ARTHUR T. FAULK, M.D.		22d. ADDRESS VAH Baltimore 18 Md Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-17-61	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City, town or county) (State) Baltimore Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight Inc		25a. REC'D BY REGISTRAR OCT 17 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Kraus			

MEDICAL CERTIFICATION

TO FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

11008

11011



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11079						11069					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY Baltimore						a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard						b. COUNTY Maryland					
c. LENGTH OF STAY IN 1b 3 Days						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						d. STREET ADDRESS 1010 Lamont Street					
3. NAME OF DECEASED (Type or print) FELIX FLEMING						4. DATE OF DEATH October 8 19 61					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 8, 1898		9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Brick Yard				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Bill Fleming				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW-1 218-09-5277				17. INFORMANT Clin Rec VAH Balto Md Ft Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) ARTERIOSCLEROSIS, GENERAL										INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMPHYSEMA											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 5, 1961 , to Oct. 8, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 8, 1961 , and that death occurred at 5:30 a.m. from the causes and on the date stated above.											
22a. SIGNATURE Paul Bormel M.D.						22b. DATE SIGNED 10-8-61					
22c. PHYSICIAN'S NAME (Type) Paul Bormel M.D.						22d. ADDRESS VAH Baltimore Md - Ft Howard Division					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10-11-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson						25a. REC'D BY REGISTRAR OCT 11 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

VR A15 (4)
15M 9/60

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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11080 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11070									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point, Md. c. LENGTH OF STAY IN tb Bethlehem Steel Hospital d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Md. d. STREET ADDRESS Rt. 14 Box 295 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Milton Burnett Fortman					4. DATE OF DEATH October 26 1961				
5. SEX m					6. COLOR OR RACE white				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 7/4/08				
9. AGE (In years last birthday) 53					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance					10b. KIND OF BUSINESS OR INDUSTRY Construction				
11. BIRTHPLACE (State or foreign country) Balto Co. Md					12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME John Fortman					14. MOTHER'S MAIDEN NAME Carrie Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 214-16-3197				
17. INFORMANT Mrs Thelma G Fortman					Address Box 295 Balto 20 Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 42011 DUE TO Germany Occlusion Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 15 min									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)									
ACTUAL SIGNATURE Jack E Collins EXAMINER'S NAME (Type) Jack E Collins DATE SIGNED 16-2761									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF 10-30-1961									
22c. NAME OF CEMETERY OR CREMATORY Ebenezer Meth Cemetery									
22d. LOCATION (City, town, or country) (State) Chase Maryland									
23. FUNERAL DIRECTOR ADDRESS Richard H. Louch, Funeral Home 7401 B. B. Rd.									
24a. REC'D BY REGISTRAR OCT 30 '61									
24b. REGISTRAR'S SIGNATURE Arthur S. Evans									

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11081

11071

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oella</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>739 Oella Ave</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oella</u> d. STREET ADDRESS <u>1739 Oella Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Madalen France</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>2/10/01</u> 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>Oct. 12 1961</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Pfeiffer</u> 14. MOTHER'S MAIDEN NAME <u>Brooks</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. <u>443X</u> 17. INFORMANT <u>Mrs. Katherine Lemmerman</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure Acute</u> (b) <u>Hypertensive Cardio Vascular</u> (c) <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/2/61</u> to <u>10/12/61</u> that (I) last saw the deceased alive on <u>10/2/61</u> and that death occurred <u>10/12/61</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W. E. McGrath M.D.</u>		22b. DATE SIGNED <u>10/12/61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>1303 Frederick Rd Catonsville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/15/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		23d. LOCATION (City, town, or county) (State) <u>Howard Co. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Don</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>OCT 16 '61</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11082

CERTIFICATE OF DEATH

11072

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson 4</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>527 Valley View Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson 4</u> d. STREET ADDRESS <u>527 Valley View Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) <u>Harry F. Frank</u>		4. DATE OF DEATH Month <u>October</u> Day <u>4</u> Year <u>1961</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 9, 1896</u>		9. AGE (In years last birthday) <u>65</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(ret'd) Official</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>William M. Frank</u>						14. MOTHER'S MAIDEN NAME <u>Helene D. Hoot</u>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>214-36-8550</u>				17. INFORMANT <u>Carl Wallace</u> , 113 East Lake Avenue													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic hypertensive C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) _____												INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____																					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____		(County) _____		(State) _____									
21. I certify that (I) (this hospital) attended the deceased from <u>24 Oct., 1956</u> to <u>4 Oct., 1961</u> , that (I) (we) last saw the deceased alive on <u>4 Oct., 1961</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.																					
22a. SIGNATURE <u>Joseph E. Muse Jr.</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED _____											
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Muse, M.D.</u>						22d. ADDRESS <u>2725 North Charles Street, Zone 18</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				23b. DATE THEREOF <u>10-6-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>				23d. LOCATION (City, town or county) <u>Baltimore</u> (State) _____											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson, Inc., 1050 York Road, Zone 4</u>						ADDRESS _____		25a. REC'D BY REGISTRAR <u>OCT 10 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loch Raven Village</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Loch Raven Village</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1911 Redwood Ave.</u>		d. STREET ADDRESS <u>1911 Redwood Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Cesare</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-23-1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Stone Cutter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>	9. AGE (In years last birthday) <u>80</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Francesco Franzoni</u>		14. MOTHER'S MAIDEN NAME <u>Rose (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>311X</u>		16. SOCIAL SECURITY NO. <u>219070614</u>	
17. INFORMANT <u>Amelia C. Franzoni</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Generalized Arteriosclerosis</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic CVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>10 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from <u>May 10, 1961</u> to <u>Oct 7, 1961</u> , that (I) (the) last saw the deceased alive on <u>Oct 6, 1961</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph F. hi Pira</u> M.D.		22b. DATE SIGNED <u>10/7/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH F. hi PIRA</u>		22d. ADDRESS <u>8400 Loch Raven Blvd. Baltore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>10-10-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>OCT 10 '61</u>	
ADDRESS <u>5305 Harford Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

11055

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "The" and "of" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be expedited within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Baltimore		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE		Maryland		b. COUNTY		Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Essex		c. LENGTH OF STAY IN 1b		X		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Essex	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		162 Silver Lane Road		d. STREET ADDRESS		162 Silver Lane Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Lucy		Middle Virginia		Last Gardner		4. DATE OF DEATH Month October		Day 18 Year 19 61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		February 25, 1885		76 yrs.		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife				Baltimore, Maryland		U.S.A.					
13. FATHER'S NAME		William Muir		14. MOTHER'S MAIDEN NAME		unknown Dennis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		no		16. SOCIAL SECURITY NO.		212-05-8401-B		17. INFORMANT Address		John Gardner, 2428 East Fayette Street	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		420.0		DUE TO		Anterior Subarachnoid Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH		4 yrs.	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		(b)		DUE TO		Hemorrhagic Anterior Subarachnoid					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that (I) (this hospital) attended the deceased from March 1955 to Oct 18 1961, that (I) (we) last saw the deceased alive on Oct 18 1961, and that death occurred at 9:15 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Robert J. Lyden		M.D.		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		Robert J. Lyden, M.D.		22d. ADDRESS		815 Eastern Avenue, Baltimore 1, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
BURIAL		10-21-61		Parkwood Cemetery		3310 Taylor Avenue					
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. Cook, Inc., 1217 St. Paul Street				OCT 24 '61		Arthur L. Kraus					

11074

11084

(M)

101 River Lane Road
Gardner
October 18

101 River Lane Road
Gardner
October 18

February 25, 1968
Baltimore, Maryland
Unknown

February 25, 1968
Baltimore, Maryland
Unknown

512-02-6401-B John Gardner, 948 West Elysian

no

815 Eastern Avenue, Baltimore 2, Md

Robert A. Taylor, Jr.

3310 Taylor Avenue

Portwood Cemetery

10-21-63

SPITAL

Mr. John, Inc., 1517 St. Paul Street

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND

11085

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 15 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before death) a. STATE Maryland b. COUNTY Baltimore 29 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 512 Glen Allen Drive d. STREET ADDRESS 512 Glen Allen Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last TWITE WITZCH GEISLER				4. DATE OF DEATH Month Day Year October 5 1961															
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 24, 1895		9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Explosives				11. BIRTHPLACE (County & State, or foreign country) Allison Park, Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME William Geisler				14. MOTHER'S MAIDEN NAME Elizabeth Deitz				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 206-01-0038				17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) CARCINOMATOSIS WITH JAUNDICE DUE TO (b) CARCINOMA OF URINARY BLADDER WITH METASTASIS TO (c) PERIAORTIC NODES AND LIVER ILEO-LOOP BLADDER CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1. Operation - Total cystectomy with ileo-loop, 7/60. Operation 2. Exploratory laparotomy, 7/17/61 - metastatic Carcinoma, liver & periaortic nodes.												INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS UNKNOWN 15 MONTHS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) September 20, 1961		20e. (County) October 5, 1961		20f. (State) 1:55							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 5, 1961 to October 5, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 5, 1961 , and that death occurred at 1:55 M, from the causes and on the date stated above.																			
22a. SIGNATURE <i>Thomas F. Crahan</i> THOMAS F. CRAHAN, M.D.				22b. DATE 10/5/61				22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 10-5-61		23c. NAME OF CEMETERY OR CREMATORY Mount Royal Cemetery				23d. LOCATION (City, town or county) (State) Glenshaw, Pennsylvania									
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14				25a. REC'D BY REGISTRAR OCT 10 '61				25b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>											

39011



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0187 019 0000-1 1111e 0000-0001

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AMENDED BY

COURT ORDER

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
amend items 3,8,13,14 per co g974 4-15-16 vt

CERTIFICATE OF DEATH

Reg. Dist. No. 11076

11086

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 774 West Hills Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) AKA Eva Maria Bavota EVA GENTILE		4. DATE OF DEATH Month 10 Day 17 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 April 25, 1892
9. AGE (In years last birthday) 69 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Michele Michael Bavota		14. MOTHER'S MAIDEN NAME Maria Michela Caporicci Mary Caporicci	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. INFORMANT Mrs. Mary Krein (Daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, sigmoid colon 153.3 DUE TO ADVANCED AND METASTATIC Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 8 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 9, 1961 , to October 16, 1961 , that I last saw the deceased alive on October 19, 1961 , and that death occurred at 1:55 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5000 BALTO NAT'L PIKE DATE SIGNED 10/17/61 ACTUAL SIGNATURE Melvin N. Borden M.D. BALTO 29, MD PHYSICIAN'S NAME (Type) Melvin N. BORDEN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/61	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond C. Link		24a. REC'D BY REGISTRAR Glen Burnie, Md.	
24b. REGISTRAR'S SIGNATURE Arthur L. Kiana		DATE OCT 19 '61	

Page 4
hours after death.
The law requires that the death certificate be executed within 72 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11811

CERTIFICATE OF DEATH

11811

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2/17/1/25

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11087

11077

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8125 Dalesford Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>8125 Dalesford Road</u>			
3. NAME OF DECEASED (Type or print) <u>Miss Joan Eleanor German</u>		4. DATE OF DEATH Month <u>October</u> Day <u>23rd</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <u>Nov. 11, 1946</u>		9. AGE (In years last birthday) <u>14</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James H. German</u>		14. MOTHER'S MAIDEN NAME <u>Nannie B. Matthews</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. James H. German 8125 Dalesford Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rheumatic Mitral Valvular Disease, Chronic</u> 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 1954</u> to <u>Oct 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct 20, 1961</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph F. Chi Pira M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/24/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH F. CHIPIRA M.D.</u>		22d. ADDRESS <u>8400 Wood Haven Rd. Kott</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/27/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem.</u>			
23d. LOCATION (City, town or county) <u>BALTIMORE Md.</u>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>		25a. REC'D BY REGISTRAR <u>OCT 27 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

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[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11088

11078

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-Catonsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5 South Beechwood Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 5 South Beechwood Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard Riley Gilner		4. DATE OF DEATH Month October Day 28 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo Engraver (Retail)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 55 yrs.
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry J. Gilner		14. MOTHER'S MAIDEN NAME Mary Callahan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. Mrs. Mary G. Ellard-5 South Beechwood Ave.	
17. INFORMANT Mrs. Mary G. Ellard-5 South Beechwood Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 350X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) Parkinson's Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 61 to 10/28 , 19 61 , that (I) (we) last saw the deceased alive on 10/1 , 19 61 , and that death occurred at 6A M., from the causes and on the date stated above.			
22a. SIGNATURE James J. Nolan MD		22b. DATE SIGNED 10/28/61	
22c. PHYSICIAN'S NAME (Type) J. J. NOLAN MD		22d. ADDRESS 1 Mallow Hill Ave Baltimore 29, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-30-61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Siskewicz & Sons		25a. REC'D BY REGISTRAR DATE OCT 31 '61	
ADDRESS Balto. 17, Md.		25b. REGISTRAR'S SIGNATURE Clairton S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **11079**

11089

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN lb 8 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3420 Dunhaven Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First RUSSELL Middle LEE Last GODSEY				4. DATE OF DEATH Month October Day 1st Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 11, 1899	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1st Helper Open Hearth Steel		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Godsey		14. MOTHER'S MAIDEN NAME Mary Wommack	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WWI		16. SOCIAL SECURITY NO. 214-05-9313		17. INFORMANT Margaret L. Godsey		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THROAT 148X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 148X DUE TO (c) 148X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 148X						INTERVAL BETWEEN ONSET AND DEATH 12 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore Co.		20h. (State) Maryland	
21. I certify that I attended the deceased from June 19 61 , to 1 October 19 61 , that I last saw the deceased alive on 1 October 19 61 , and that death occurred at 4:00 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3401 Dundalk Avenue DATE SIGNED 10/3/61							
ACTUAL SIGNATURE W.E. Baermann				M.D. 3401 Dundalk Avenue			
PHYSICIAN'S NAME (Type) W.E. Baermann, M.D.				Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/61		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.				24a. RECEIVED BY REGISTRAR DATE Oct 6 '61		24b. REGISTRAR'S SIGNATURE Walter S. Adams	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11090

11080

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write street and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1200 Harwall Rd</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Belts</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>1200 Harwall Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Anna I. Grafton</u>		4. DATE OF DEATH Year <u>19</u> Month <u>Oct.</u> Day <u>25</u>		5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 28, 1907</u>		9. AGE (In years last birthday) <u>53</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERVISOR, U.S. GOV'T</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>MARTIN F. FABIANI</u>						14. MOTHER'S MAIDEN NAME <u>ROSE DIEGEL</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____				16. SOCIAL SECURITY NO. (If yes give war or date of service) _____		17. INFORMANT Address <u>MR. NATHAN GRAFTON, 1200 HARWALL RD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ovarian Cancer</u> <u>175.0</u> DUE TO (b) <u>With Metastases</u> Conditions, if any, which gave rise to immediate cause (c) _____ (e), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH <u>about 10 months</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____													
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____		(County) _____		(State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 15, 1961</u> to <u>Oct 25, 1961</u> that (I) (we) last saw the deceased alive on <u>Oct 25, 1961</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.													
22a. SIGNATURE <u>M Paul Beyerly</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/25/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>M Paul Beyerly</u>						22d. ADDRESS <u>3820 York Rd Balto Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>OCT. 28/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WESTERN CEMETRY</u>				23d. LOCATION (City, town or county) <u>BALTO. MD.</u> (State) <u>MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE F.D. 4101 EDMONDSON AVE</u>						25a. REC'D BY REGISTRAR <u>Oct 26 8 56 '61</u>		25b. REGISTRAR'S SIGNATURE <u>C. J. ...</u>					

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXAMINED WITHIN 24 HOURS AFTER DEATH. THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR. AFTER THIS CERTIFICATE HAS BEEN SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY FILLED IN BY THE FUNERAL DIRECTOR, PAGE 3 SHOULD BE DETACHED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPT. OF HEALTH PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT, WITHIN 72 HOURS AFTER DEATH.

VR A15 (4)
 15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11091

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11081

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Long Beach</u>				c. LENGTH OF STAY IN 1b <u>Long Beach</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 302, Chesapeake Ave.</u>				d. STREET ADDRESS <u>Box 302, Chesapeake Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>Marie</u> Last <u>Graham</u>				4. DATE OF DEATH Month <u>10</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/26/1889</u>		9. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard Lewis</u>				14. MOTHER'S MAIDEN NAME <u>Dora Luers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Lawrence Zorn, nephew, above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>260X</u> DUE TO <u>Generalized Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>5 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C. Collins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Jack C. Collins</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/11/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Schwartz Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Schimunek</u> <u>3331 Brehms Lane</u>				24a. REC'D BY REGISTRAR <u>10/11/61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11092

11082

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>1 Da.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie, Md.</u> d. STREET ADDRESS <u>303 First Ave., S. W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Grahe</u> Last <u>Grahe</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>27</u> Year <u>1961</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-13-1878</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u>		10. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (Const. Eng.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Cummings & Hent</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>215 05 2614</u>				17. INFORMANT <u>Records: Spring Grove State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia.</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease.</u> DUE TO (c) <u>Arteriosclerosis, generalized, severe.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>10-26-61 11:30</u> to <u>10-27-61</u> , 19 <u>61</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10-27-61</u> 19 <u>61</u> , and that death occurred at <u>2:00</u> M, from the causes and on the date stated above.																			
22a. SIGNATURE <u>Stella Wachsler</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>10-27-61</u>											
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>				22d. ADDRESS <u>Spring Grove State Hospital</u> <u>Catonsville, Maryland</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>30th Oct. '61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Glen Burnie, Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard P. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 30 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

11888

11888

(M)

(1)

[Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.]

11093

CERTIFICATE OF DEATH

Reg. Dist. No. 11083

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Heatonville</i>		c. LENGTH OF STAY IN 1b <i>47 X 3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>the House in Pines</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Louis</i> Middle <i>-</i> Last <i>GREENBERG</i>		4. DATE OF DEATH Month <i>10</i> Day <i>30</i> Year <i>1961</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>78</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance agent</i>		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
13. FATHER'S NAME <i>Morris Greenberg</i>		14. MOTHER'S MAIDEN NAME <i>Soldie unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Ray Greenberg - same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Cardio-vascular Disease</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i> <i>10 yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>9-6-1961</i> to <i>10-30-1961</i> , that I last saw the deceased alive on <i>10-29-1961</i> , and that death occurred at <i>1 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i>		ADDRESS (Street, city or town, state) <i>6209 Frederick Ave. Baltimore-28, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher, MD.</i>		DATE SIGNED <i>10-30-61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>10-31-61</i>	<i>Arlington</i>	<i>Balto Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i>		ADDRESS <i>2100 Eutan Place</i>	
24a. REC'D BY REGISTRAR DATE <i>OCT 31 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1934

1934

14

<p>NAME OF DECEASED</p> <p><i>John Doe</i></p>		<p>AGE</p> <p><i>45</i></p>	
<p>SEX</p> <p><i>Male</i></p>		<p>RACE</p> <p><i>White</i></p>	
<p>DATE OF DEATH</p> <p><i>Jan 15 1934</i></p>		<p>TIME OF DEATH</p> <p><i>10:30 AM</i></p>	
<p>PLACE OF DEATH</p> <p><i>Home</i></p>		<p>CAUSE OF DEATH</p> <p><i>Heart Disease</i></p>	
<p>DIAGNOSIS</p> <p><i>Myocardial Infarction</i></p>		<p>IMMEDIATE CAUSE</p> <p><i>Coronary Thrombosis</i></p>	
<p>UNDERLYING CAUSE</p> <p><i>Arteriosclerosis</i></p>		<p>INTERESTED PERSONS</p> <p><i>John Doe, Jr.</i></p>	
<p>SIGNATURE OF PHYSICIAN</p> <p><i>Dr. J. A. Smith</i></p>		<p>SIGNATURE OF REGISTRAR</p> <p><i>W. B. Jones</i></p>	
<p>DATE OF SIGNATURE</p> <p><i>Jan 16 1934</i></p>		<p>DATE OF SIGNATURE</p> <p><i>Jan 16 1934</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE		b. COUNTY	
Baltimore MARYLAND				Md		Balt	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
Baltimore 28				Baltimore 29		434 S. Augusta Ave	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
House in Pines							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		5. AGE (In years last birthday)	
First Middle Last				Month Day Year		IF UNDER 1 YEAR IF UNDER 24 HRS.	
William T. Grindell				Oct. 29 1961		Months Days Hours Min.	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
M	W		Oct. 22, 73	88 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Linotype op. Sun Paper				Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			
George Grindell		(unknown)		no			
16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		Albert Atkinson					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						1 mo.	
422 1 DUE TO						15 yr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Arteriosclerotic Cardio-Vascular Disease							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
19							
21. I certify that (I) (the hospital) attended the deceased from 9-4-1960 to 10-29-1961, that (I) (we) last saw the deceased alive on 10-28-1961, and that death occurred at 2P.M. from the causes and on the date stated above.							
22a. SIGNATURE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
Wilmer K. Gallagher				M.D.		10/30/61	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
Wilmer K. Gallagher M.D.				6209 Frederick Ave., Baltimore 28, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Burial		11/2/61		Cathedral		Balt. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		25a. REC'D BY REGISTRAR DATE	
Macdrott + Son				28		NOV 3 '61	
						25b. REGISTRAR'S SIGNATURE	
						Arthur S. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11095						11085					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY Baltimore						a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville						b. COUNTY Baltimore					
c. LENGTH OF STAY IN 1b 7yr8mth3dys						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL						d. STREET ADDRESS 200 East Fort Avenue					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED						4. DATE OF DEATH					
First Middle Last Charles I. Gude						Month Day Year October 8 1961					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 17, 1915		9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shipyard worker				10b. KIND OF BUSINESS OR INDUSTRY shipyard				11. BIRTHPLACE (County & State, or foreign country) Maryland, Baltimore			
12. CITIZEN OF WHAT COUNTRY? U. S. A.											
13. FATHER'S NAME Charles Gude						14. MOTHER'S MAIDEN NAME Elizabeth Bachman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown No.						16. SOCIAL SECURITY NO. unknown					
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia											
DUE TO											
Conditions, if any, which gave rise to immediate cause (b)											
DUE TO											
(a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)				(State)			
21. I certify that (if this hospital) attended the deceased from Feb. 5 1961 to Oct. 8 1961, that (we) last saw the deceased alive on Oct. 8 1961, and that death occurred at 9:40 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Stella Wachslar M.D.						22b. DATE SIGNED 10-9-61					
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.						22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10-13-61				23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery			
23d. LOCATION (City, town or county) Baltimore				(State) Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Seiler						25a. REC'D BY REGISTRAR DATE OCT 13 '61					
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

VR A15 (4)
15M 9/60

11084

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11086

11095

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Dundalk Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dundalk</u>				d. STREET ADDRESS <u>2042 East Preston Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Joe</u> Middle <u>Guin</u> Last 4. DATE OF DEATH Month <u>October</u> Day <u>3rd</u> Year <u>19 61</u>							
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>September 10-08</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	IF UNDER 24 HRS. Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Union Co. N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Guin</u>				14. MOTHER'S MAIDEN NAME <u>Renie White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Effie Guin</u>		17. INFORMANT <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>812X</u> DUE TO <u>Crushing injury to chest and upper abdomen</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>uppu abdomen</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <u>Truck backed over him.</u>					
20c. TIME OF INJURY Month, Day, Year <u>2:00 p.m. 10-3-61</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) (County) (State) <u>Dundalk Balto Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10/7/61</u>	
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/7/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy C. Wilson</u>				1000 Brantley Ave.		24a. REC'D BY REGISTRAR DATE <u>OCT 11 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11025

FOR STATE
HEALTH DEPT.

(M)

NAME OF DECEASED
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
EDUCATION
RELIGION
MARRIAGE
PREVIOUS ILLNESS
CAUSE OF DEATH
MANNER OF DEATH
PLACE OF DEATH
DATE OF DEATH
TIME OF DEATH
SIGNATURE OF EXAMINER
DATE OF EXAMINATION

BOB

1. Family history of disease or abnormality
2. Habits of deceased (smoking, drinking, etc.)
3. History of disease or abnormality
4. History of injury or trauma
5. History of surgery
6. History of hospitalization
7. History of travel
8. History of occupation
9. History of education
10. History of religion
11. History of marriage
12. History of previous illness
13. History of cause of death
14. History of manner of death
15. History of place of death
16. History of date of death
17. History of time of death
18. History of signature of examiner
19. History of date of examination

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11097

11087

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. LENGTH OF STAY IN 1b 2 Months		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penn. b. COUNTY Gettysburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1823 Mayfield Ave		d. STREET ADDRESS 134 Hanover St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MINNIE A GUTMANN		First Middle Last		4. DATE OF DEATH Oct. 1, 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1881	9. AGE (In years last birthday) 80 1/2 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Andreas, Penn.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Elias Mantz		14. MOTHER'S MAIDEN NAME Sarah Lechleitner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT John E. Gutmann, 1823 Mayfield Ave. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) HYPERTENSION					INTERVAL BETWEEN ONSET AND DEATH 24 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 2 Sept 1961 to 30 Sept 1961 , that (I) was last saw the deceased alive on 30 Sept 1961 , and that death occurred at HP M, from the causes and on the date stated above.					
22a. SIGNATURE George E. Groleau		M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) George E. Groleau		22d. ADDRESS 5608 Main Street, Elkridge, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/4/61	23c. NAME OF CEMETERY OR CREMATORY New Morivia	23d. LOCATION (City, town, or county) (State) Emmaus, Penn		
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave		ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 3 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Hanna

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11037

14

11037

BRITISH CASE OF CROWN

MINISTERS A. GUMMING

Female White

X

Rome

First Name

No

None

La. Orleans

Anders. Penn.

181

John F. O'Connell, 1017 Maryland Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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2
1
VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11098 CERTIFICATE OF DEATH 11088											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN lb 46yr9mo4da					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland d. STREET ADDRESS 834 N. Gay St.						
3. NAME OF DECEASED (Type or print) William Hagerman					4. DATE OF DEATH Oct. 30 1961					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-29-1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Box maker					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Hagerman					14. MOTHER'S MAIDEN NAME Caroline Klingmeyer						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown					16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Records: Spring Grove State Hospital				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulated right scrotal hernia 560.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Direct-indirect inguinal hernia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic heart disease with obliterative pericarditis										INTERVAL BETWEEN ONSET AND DEATH 4-6 hours 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that M (this hospital) attended the deceased from 1-26-1915 to 10-30-1961 19....., that (H) (we) last saw the deceased alive on 10-30-1961 19....., and that death occurred at 7:55 A.M., from the causes and on the date stated above.											
22a. SIGNATURE Imre Kopits M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/31/61				
22c. PHYSICIAN'S NAME (Type) Imre Kopits, M. D.					22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-2-61		23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery			23d. LOCATION (City, town or county) (State) Baltimore				
24 FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street					ADDRESS		25a. REC'D BY REGISTRAR NOV 3 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume		

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8-11-1908

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11-11-1908
St. Patrick's Cemetery
1117 St. Paul Street
New York, N. Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

11099

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11089

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bent Nursing Home		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Esmereldo Halzapfil		4. DATE OF DEATH Month October Day 22 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 81 yrs.
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Francis Marion Hale		14. MOTHER'S MAIDEN NAME Eichelberger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - aspiration 4500 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 19 61 , to October 22, 1961 , that (I) (we) last saw the deceased alive on October 20, 1961 , and that death occurred at 11:04 AM , from the causes and on the date stated above.			
22a. SIGNATURE Clarence E. McWilliams M.D.		22b. DATE SIGNED October 27 1961	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 11904 Reisterstown Rd Reisterstown Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 11/25/61 BURIAL	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL	23d. LOCATION (City, town or county) (State) HAGERSTOWN MD
24. FUNERAL DIRECTOR'S SIGNATURE Paul E. Shumway		25. REC'D BY REGISTRAR OCT 24 '61	
ADDRESS 3617 Chestnut Ave		25b. REGISTRAR'S SIGNATURE Arthur L. Hance	

11000

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(M)

1001 McGleam St.

Post,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11100
CERTIFICATE OF DEATH

11090

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Stevenson c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) "Withywood"		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson d. STREET ADDRESS "Withywood" e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth Luck Hammond		4. DATE OF DEATH Month Oct. Day 16 Year 19 61	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1905
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 16	IF UNDER 24 HRS. Hours 19 Min. 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Va.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Preston Luck	
14. MOTHER'S MAIDEN NAME Lucille Ashton		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	
16. SOCIAL SECURITY NO. **		17. INFORMANT Hall Hammond Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arterio-sclerotic heart disease and hypertension DUE TO (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 3-4 hrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-29-43 , 19....., to death....., 19....., that (I) (we) last saw the deceased alive on 10-10-61 , 19....., and that death occurred at 11:30 a/m , from the causes and on the date stated above.			
22a. SIGNATURE Warde B. Allan, M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 10-17-61 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Warde B. Allan, M. D.		22d. ADDRESS 6 E. Eager St., Balto. 2, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-18-61	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City, town or county) (State) Pikesville Md.
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR OCT 20 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hanes	

4

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11101

11091

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5611 East Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Donna</u> Middle <u>Camilla</u> Last <u>Harant</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12 1947</u>		9. AGE (In years last birthday) <u>14</u> yrs.	IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis C. Harant</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth M. Chaney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Francis C Harant</u> Address <u>5611 East Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHO-PNEUMONIA</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGENITAL CEREBRAL MALFORMATION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAR. 15 1948</u> to <u>OCT. 2 1961</u> , that (I) (we) last saw the deceased alive on <u>10/2 1961</u> , and that death occurred at <u>2:18 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John W. Machen</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>JOHN W. MACHEN M.D.</u>	
				22d. ADDRESS <u>6331 BELAIR ROAD (6)</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-5-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Balto 6 Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Pippel Bros. 7110 Belair Rd</u>				25a. REC'D BY REGISTRAR <u>DATE OCT 4 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 9 Hrs.45 M. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bellevue d. STREET ADDRESS -- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) HOWARD		First HOWARD		Middle --		Last HASKINS		4. DATE OF DEATH Month October Day 4 Year 19 61							
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 1, 1887		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b. KIND OF BUSINESS OR INDUSTRY Produce				11. BIRTHPLACE (County & State, or foreign country) Deep Neck, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Perry Haskins				14. MOTHER'S MAIDEN NAME Cornelia Brammel				17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 145-14-3767				17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA, LEFT LUNG 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BILATERAL PULMONARY EMPHYSEMA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 DAY + UNKNOWN										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10:40 AM		20f. (City or town) October 4, 1961		20g. (County) October 4, 1961		20h. (State) October 4, 1961					
21. I certify that he (this hospital) attended the deceased from October 4, 1961 to October 4, 1961 , that we (we) last saw the deceased alive on October 4, 1961 , and that death occurred at 8:25 P.M. from the causes and on the date stated above.															
22a. SIGNATURE Sebastian Russo M.D.				22b. DATE SIGNED 10/5/61				22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct. 7-1961				23c. NAME OF CEMETERY OR CREMATORY Royal Oak Cemetery				23d. LOCATION (City, town or county) (State) Royal Oak Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiells				25a. REC'D BY REGISTRAR DATE OCT 9 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				25c. ADDRESS Easton, Md.			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|----------------------------------|--|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 11103 Item 23b, Film G299 11/6/61 iwk 11093 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Fort Howard</u> | | | | | | c. LENGTH OF STAY IN lb
<u>66 days</u> | | | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | | | | | d. STREET ADDRESS
<u>1718 Abbottston Street</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Veterans Administration Hospital</u> | | | | | | a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>WILLIAM</u> Middle <u>A.</u> Last <u>HEATLEY</u> | | | | | | 4. DATE OF DEATH
Month <u>October</u> Day <u>28</u> Year <u>19 61</u> | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 16, 1889</u> | | 9. AGE (In years last birthday)
<u>72</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Roller Maker</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Steel Mill</u> | | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Passiac, New Jersey</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>William Heatley</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary McShane</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<u>Yes</u> <u>WWI</u> | | | | 16. SOCIAL SECURITY NO.
<u>213-03-4977</u> | | | | 17. INFORMANT
<u>Clinical Records, VAH, Baltimore, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u>
<u>490X</u> <u>XXXXX</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u>
DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRAIN SYNDROME</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u>
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
INTERVAL BETWEEN ONSET AND DEATH
<u>5 DAYS</u>
<u>UNKNOWN</u> | | | | | | | | | | | |
| 21. I certify that (If <input checked="" type="checkbox"/> this hospital) attended the deceased from <u>August 23, 19 61</u> to <u>October 28, 19 61</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 28, 19 61</u> , and that death occurred at <u>1:10 PM</u> from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>M. Lawrence Rubin</u> M.D. | | | | | | 22b. DATE SIGNED
<u>10/29/61</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>M. LAWRENCE RUBIN, M.D.</u> | | | | | | 22d. ADDRESS
<u>VAH, BALTO. MD. FT HOWARD DIV.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | | | 23b. DATE THEREOF
<u>10/31/61</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore Cemetery</u> | | | |
| 23d. LOCATION (City, town or county) (State)
<u>E. North Ave. & Rose Sts</u> | | | | 24. FUNERAL DIRECTOR'S SIGNATURE
<u>J. Melville Jenkins</u> | | | | 25a. REC'D BY REGISTRAR
<u>OCT 31 '61</u> | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles S. Kline</u> | | | | 25c. DATE
<u>OCT 31 '61</u> | | | | 25d. ADDRESS
<u>Baltimore, Md.</u> | | | |

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|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> | | c. LENGTH OF STAY IN 1b <u>2 WEEKS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Caton Ridge Nursing Home</u> | | d. STREET ADDRESS <u>1807 Frederick Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Catherine Hendricks</u> | | 4. DATE OF DEATH <u>October 20, 1961</u> | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 1, 1874</u> | |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Switzerland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Un Known Cook</u> | | 14. MOTHER'S MAIDEN NAME <u>Un Known</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>Martin Hendricks</u> | | Address <u>1935 Grinnalds Ave</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
(a) <u>Cerebellar Thrombosis</u>
DUE TO
(b) <u>Cerebellar Arteriosclerosis</u>
DUE TO
(c) <u>Arteriosclerosis generalized</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>1 yr.</u>
<u>2 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2-3</u> 19 <u>61</u> to <u>10-20</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10-20</u> 19 <u>61</u> , and that death occurred at <u>7:25</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John P. Urlock Jr.</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>JOHN P. URLOCK JR</u> | | 22d. ADDRESS <u>1227 WASH BLVD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>10-24-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>WESTERN</u> | | 23d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Geo. L. Schwab</u> | | 25a. REC'D BY REGISTRAR <u>DATE OCT 24 '61</u> | |
| ADDRESS <u>210 Frederick Ave</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur J. Kraus</u> | |

11085

CERTIFICATE OF DESIGN

11085

(N)

CERTIFICATE OF DEATH

11096

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
<div style="text-align: right; font-weight: bold;">MARYLAND</div> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY 3 VO 1-4
 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Presbyterian Home | | d. STREET ADDRESS
4028 Falls Road | |
| 3. NAME OF DECEASED
(Type or print) Josephine | | 4. DATE OF DEATH
Month October Day 9 Year 19 61 | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 26, 1874 | |
| 9. AGE (In years last birthday) 87 yrs. | | 10. IF UNDER 1 YEAR
Months 8 Days 15 | |
| 11. IF UNDER 24 HRS.
Hours 10 Min. 10 | | 12. CITIZEN OF WHAT COUNTRY?
None | |
| 13. FATHER'S NAME
Daniel B. Hendrix | | 14. MOTHER'S MAIDEN NAME
Mary Agnes Fulton | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
Mrs. T.E. Elliott, Presbyterian Home | |
| 17. INFORMANT
Address Mrs. T.E. Elliott, Presbyterian Home | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH
10 min | |
| (b) Cerebral Arteriosclerosis | | years | |
| (c) Generalized Arteriosclerosis | | years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Carcinoma of the breast | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the decedent) attended the deceased from January 1958, to October 9, 1961, that (I) (we) last saw the deceased alive on October 5, 1961, and that death occurred at 9:15 pm from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
S.J. Venable, Jr. M.D. | | 22b. DATE SIGNED
Oct 10, 1961 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS
7215 York Road, Baltimore 12, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-12-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Stewartstown | | 23d. LOCATION (City, town or county) (State)
Stewartstown, Penna. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John O. Mitchell & Sons, Inc. 1900 Eutaw Place | | 25a. REC'D BY REGISTRAR OCT 13 1961 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | |

11000

2011

(M)

(1)

x

January 1st to December 31st

for the year ending December 31st, 1911

for the year ending December 31st, 1911

for the year ending December 31st, 1911

for the year ending December 31st, 1911

for the year ending December 31st, 1911

for the year ending December 31st, 1911

for the year ending December 31st, 1911

for the year ending December 31st, 1911

CERTIFICATE OF DEATH

Reg. Dist. No.

11107

11097

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | c. LENGTH OF STAY IN 1b
50 yrs. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
5808 Westwood Ave | | | | e. STREET ADDRESS
5808 Westwood Ave. | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Ernestine Middle W. Last Herauf (Reinhardt) | | | | 4. DATE OF DEATH
Month October Day 8 Year 1961 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
5-18-1889 | |
| 9. AGE (In years last birthday) yrs.
72 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (State or foreign country)
Stettin-Germany | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Franz Loessin | | | | 14. MOTHER'S MAIDEN NAME
Ernestine Zastrow | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | | |
| INFORMANT
Owen E. Tormollan Jr. | | | | Address
5808 Westwood Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 151X Adenocarcinoma Metastasis
DUE TO Primary Ca of Stomach
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. INTERVAL BETWEEN ONSET AND DEATH
9-25-61
3 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Sept 25, 1961 to Oct 8, 1961 , that I last saw the deceased alive on Oct 8, 1961 and that death occurred at 6 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 5808 Westwood Ave. Baltimore Md. DATE SIGNED Oct 10 1961 | | | | | | | |
| ACTUAL SIGNATURE Michael J. Grossfeld M.D. | | | | DATE SIGNED Oct 10 1961 | | | |
| PHYSICIAN'S NAME (Type) Michael J. Grossfeld | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-11-61 | | 22c. NAME OF CEMETERY OR CREMATORY
Jerusalem Luth. Cem. | | 22d. LOCATION (City, town, or county) (State)
Baltimore Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Lassahn Funeral Home | | | | 24a. REC'D BY REGISTRAR
Arthur L. Kline | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kline | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

11001

CERTIFICATE OF DEATH

DECEASED

RESIDENT

DATE

PLACE

TIME

CAUSE

AGE

SEX

RACE

EDUCATION

RELIGION

STATUS

OCCUPATION

PROFESSION

SIGNATURE

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS

DECEASED
RESIDENT
DATE
PLACE
TIME
CAUSE
AGE
SEX
RACE
EDUCATION
RELIGION
STATUS
OCCUPATION
PROFESSION
SIGNATURE
STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11108 CERTIFICATE OF DEATH 11099

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY — ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mt. Wilson, Maryland | | c. LENGTH OF STAY IN 1b
3 years 9 mo | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BALTIMORE City → V 01-7 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Mt. Wilson State Hospital | | | | d. STREET ADDRESS
740 N. PAYSON STREET | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First HARRY Middle ELSNORTH Last HILTNER | | | | 4. DATE OF DEATH
Month OCTOBER Day 31 Year 1961 | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
4.6.1889. | |
| 9. AGE (In years last birthday)
72 yrs. | | 10. IF UNDER 1 YEAR
Months — Days — Hours — Min. — | | 11. BIRTHPLACE (State or foreign country)
BALTIMORE MARYLAND | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
PLASTERER | | | | 10b. KIND OF BUSINESS OR INDUSTRY
HOUSE PLASTERING | | | |
| 13. FATHER'S NAME
HENRY HILTNER | | | | 14. MOTHER'S MAIDEN NAME
EMMA HISEY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
217-07-2441 | | 17. INFORMANT
Hospital Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
4200 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease
DUE TO
(c) —
INTERVAL BETWEEN ONSET AND DEATH
3 days
4 year | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
For advanced pulmonary tuberculosis | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
002X | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from JANUARY 16 1958 to OCTOBER 31 1961 , that (I) (we) last saw the deceased alive on OCT. 31 1961 , and that death occurred at 6:40 P. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Wm. Newcomer | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
10/31/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Wm. Newcomer, M.D. Superintendent | | | | 22d. ADDRESS
Mt. Wilson State Hospital, Mt. Wilson, Md. | | | |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)
BURIAL | | 23b. DATE THEREOF
11-3-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | 23d. LOCATION (City, town, or county) (State)
Baltimore | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook-Towson, Inc., 1050 York Road, Towson | | | | 25a. REC'D BY REGISTRAR
DATE NOV 3 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

11000

RECEIVED

11-3-01

M

1

[Faint, mostly illegible text, possibly a letter or report, with some words like "Dear Sir" and "Yours faithfully" visible.]

11-3-01

RECEIVED

11-3-01

BURIAL

COOLIDGE, Mrs. J. W. 1000 York Road, Toronto

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

11109

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11100

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> 28, <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓ | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore - 28</u> <u>Catonsville</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>3857 Forest Park Ave,</u> <u>3 V01-4</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital</u> | | | | d. STREET ADDRESS <u>Baltimore - 16, Md.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Rose</u> First Middle Last <u>HIRSCHMAN</u> | | | | 4. DATE OF DEATH <u>October</u> <u>1</u> <u>1961</u> Month Day Year | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1880</u> | |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | | | | | | | |
| 13. FATHER'S NAME <u>unknown</u> | | | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war and dates of service) | | | | 16. SOCIAL SECURITY NO. <u>unknown</u> | | | |
| 17. INFORMANT <u>sister:</u> Address <u>Baltimore - 7</u> | | | | Mrs. Marie STOLBERG - 3901 Forest Park Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease, in failure</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis, severe</u>
DUE TO (c) <u></u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Under nourishment</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>none</u> <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 24</u> , 19 <u>60</u> to <u>October 1</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>October 1</u> , 19 <u>61</u> , and that death occurred at <u>5:20 PM</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Imre KOPITS, M.D.</u> | | | | 22d. ADDRESS <u>Spring Grove State Hospital</u> <u>10/1/61</u>
<u>Baltimore - 28 (Catonsville), Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10-4-61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Young men</u> | | 23d. LOCATION (City, town or county) (State) <u>Balto</u> <u>Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eutaw Place</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>OCT 5 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

11108

11108

VI

11108

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A1SME
5M 9/60

1
FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--------------------------------|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 63
d. STREET ADDRESS
290 Ridge Road | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore 63 | | | | | | | | | | | | c. LENGTH OF STAY IN 1b
10 yrs | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
290 Ridge Road, Balto. 63 | | | | | | | | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
FREDERICK | | | | | | | | | | | | 4. DATE OF DEATH
10 14 1961 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. SEX
Male | | | | 6. COLOR OR RACE
White | | | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH
1-18-1891 | | | | 9. AGE (In years last birthday)
70 yrs | | | | IF UNDER 1 YEAR
Months Days | | | | IF UNDER 24 HRS.
Hours Min. | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | | | | | | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Carpenter | | | | | | | | | | | | 11. BIRTHPLACE (State or foreign country)
North Dakota | | | | | | | | | | | | 12. CITIZEN OF WHAT COUNTRY?
U S A | | | | | | | | | | | |
| 13. FATHER'S NAME
John Hoffman | | | | | | | | | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | | | | | | | | | | | 16. SOCIAL SECURITY NO.
217-07-5187 | | | | | | | | | | | | 17. INFORMANT
Mrs Lottie Hoffman Address
290 Ridge Road | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town)
(County)
(State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
10-14-61 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Howard G. Shaub | | | | | | | | | | | | M.D.
Howard G. Shaub, M.D. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | | | | | | | | | | Address (Street, city, town, or county) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | | | | | | | 22b. DATE THEREOF
10-17-1961 | | | | | | | | | | | | 22c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cem. | | | | | | | | | | | | 22d. LOCATION (City, town, or country)
Baltimore Md. | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR
Laseahn Funeral Home | | | | | | | | | | | | ADDRESS
7401 Belair Road | | | | | | | | | | | | 24a. REC'D BY REGISTRAR
OCT 17 '61 | | | | | | | | | | | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11102

| | | | |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Parkville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Parkville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>1810 Berrywood Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Dorothy</u> Middle <u>C.</u> Last <u>Hoopes</u> | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>1</u> Year <u>1961</u> | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10-9-1909</u> |
| 9. AGE (In years last birthday)
<u>51</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>10</u> Days <u>10</u> Hours <u>10</u> Min. <u>10</u> | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | 11b. KIND OF BUSINESS OR INDUSTRY
<u>housewife</u> | |
| 12. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 13. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 14. FATHER'S NAME
<u>Charles Seibert</u> | | 15. MOTHER'S MAIDEN NAME
<u>Whitemena Simpson</u> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>213424042</u> | | 17. SOCIAL SECURITY NO.
<u>213424042</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Probable Internal hemorrhage</u>
<u>155.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO <u>Carcinoma of Gall Bladder</u>
<u>with extensive metastasis</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 minutes</u>
<u>3 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>John A. Hoopes 1810 Berrywood Rd.</u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 29</u> , 19 <u>61</u> , to <u>Oct 1</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 29</u> , 19 <u>61</u> , and that death occurred at <u>3:45</u> A.M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>J. F. Palmisano</u> | | 22b. DATE SIGNED
<u>10/2/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>J. F. Palmisano, M. D.</u> | | 22d. ADDRESS
<u>6608 Loch Raven Blvd. Balto. 12, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | 23b. DATE THEREOF
<u>10-4-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Baltimore, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Ruck</u> | | 25a. REC'D BY REGISTRAR
<u>Oct 3 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | |

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CERTIFICATE OF DEATH

Reg. Dist. No. 11103

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore 4</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>8434 Greenway Road</u> | | d. STREET ADDRESS
<u>8434 Greenway Road</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Edmund C.</u> Middle <u>Horton</u> Last | | 4. DATE OF DEATH
Month <u>October</u> Day <u>5</u> Year <u>1961</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 14, 1891</u> |
| 9. AGE (In years last birthday) yrs.
<u>70</u> | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Ret. Confect Bus</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Conf Bus</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>John W. Horton</u> | | 14. MOTHER'S MAIDEN NAME
<u>Julia Ellinghaus</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>yes</u> <u>WWI</u> | | 16. SOCIAL SECURITY NO.
<u>218-32-0556</u> | |
| 17. INFORMANT
<u>Mrs Mary E. Horton</u> | | Address
<u>8434 Greenway Rd.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u>
<u>420.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
<u>15yr</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
<u>19</u> | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Apr 4, 1946</u> , to <u>Oct 5, 1961</u> , that I last saw the deceased alive on <u>Oct 3, 1961</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town) state) DATE SIGNED
<u>6100 York Rd</u> <u>6 Oct 61</u>
ACTUAL SIGNATURE <u>Frederick J. Vollmer</u> M.D. <u>Baltimore-12 Md.</u>
PHYSICIAN'S NAME (Type) <u>FREDERICK J. VOLLMER</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>Oct 9, 1961</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Balto. Nat. Cemetery</u> | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>John A. Moran</u> | | 24a. REC'D BY REGISTRAR
DATE <u>OCT 10 '61</u> | |
| ADDRESS
<u>3000 E. Baltimore St.</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Krawch</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO SPIRITUAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11113 **CERTIFICATE OF DEATH** **11104**

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
1yr10mth16dys | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville, Maryland | |
| d. STREET ADDRESS
235 Bloomsbury Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Sarah E. (Bessie) Middle Hullett Last Hullett | | 4. DATE OF DEATH
Month Oct. Day 24 Year 19 61 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 26, 1879 |
| 9. AGE (In years last birthday) 82 yrs. | | IF UNDER 1 YEAR: Months 0 Days 0
IF UNDER 24 HRS.: Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
unknown | | 14. MOTHER'S MAIDEN NAME
unk nown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
unknown | |
| 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Cerebro-vascular accident.
331X DUE TO
Conditions, if any, which gave rise to immediate cause (b) arteriosclerosis
(a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH
4 days | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 1, 1959 to Oct. 24, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 24, 1961 , and that death occurred at 4:15 a.m., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Stella Wachslar M.D. | | 22b. DATE SIGNED
Oct 27 '61 | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachslar, M. D. | | 22d. ADDRESS
SPRING GROVE STATE HOSP.
Catonsville 28, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
10-27-61 | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | 23d. LOCATION (City, town or county) (State)
Baltimore |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook, Inc., 1217 St. Paul Street | | 25a. REC'D BY REGISTRAR
OCT 27 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kline | | | |

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CERTIFICATE OF DEATH

Reg. Dist. No.

11105

| | | | | | | | |
|---|------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Towson | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Towson | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Villa Maria - Notch Cliff | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
Sister M. Sylvana (Hunn) | | | | 4. DATE OF DEATH Month Day Year
10 22 19 61 | | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5 - 31 - 1870 | | 9. AGE (In years last birthday)
91 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY
RELIGIOUS | | 11. BIRTHPLACE (State or foreign country)
Switzerland | | 12. CITIZEN OF WHAT COUNTRY?
United States | |
| 13. FATHER'S NAME
Xavier Hunn | | | | 14. MOTHER'S MAIDEN NAME
Genevieve Ast | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Sr.M. Henrica Villa Maria, Glenarm, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema
522X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
48 hours | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 19 45 , to Oct. 19 61 , that I last saw the deceased alive on Oct. 19 61 , and that death occurred at 6:15 p.m. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Dr. Charles F. O'Donnell M.D. | | | | PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
10-24-61 | | 22c. NAME OF CEMETERY OR CREMATORY
VILLA MARIA CEM. | | 22d. LOCATION (City, town, or county) (State)
NOTCHCLIFF NR TOWSON, MD. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles S. Gerley | | | | ADDRESS
901 S. CONKLING ST. BALTO., MD. | | 24a. REC'D BY REGISTRAR
DATE OCT 26 '61 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kinn | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1110

(M)

| | | | | | | | | | | | | | | | | | |
|------------------------|--|------------------------|--|-----------------------|--|-----------------------|--|-----------------------|--|-----------------------|--|------------------------|--|------------------------|--|-----------------------|--|
| NAME OF DECEASED | | AGE | | SEX | | RACE | | DATE OF BIRTH | | PLACE OF BIRTH | | CITY | | COUNTY | | STATE | |
| JAMES J. JAMES | | 45 | | M | | W | | 1880 | | NEW YORK | | NEW YORK | | NEW YORK | | NEW YORK | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY | | COUNTY | | STATE | | DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | |
| JAN 10 1920 | | 10:00 AM | | HOME | | NEW YORK | | NEW YORK | | NEW YORK | | JAN 10 1920 | | 10:00 AM | | HOME | |
| CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | | EDUCATION | | RELIGION | | MARRIAGE | | CAUSE OF DEATH | | MANNER OF DEATH | | OCCUPATION | |
| HEART DISEASE | | NATURAL | | FARMER | | HIGH SCHOOL | | CATHOLIC | | MARRIED | | HEART DISEASE | | NATURAL | | FARMER | |
| SIGNATURE OF PHYSICIAN | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | | SIGNATURE OF DECEASED | | SIGNATURE OF DECEASED | | SIGNATURE OF DECEASED | | SIGNATURE OF PHYSICIAN | | SIGNATURE OF WITNESSES | | SIGNATURE OF DECEASED | |
| JAMES J. JAMES | | JAMES J. JAMES | | JAMES J. JAMES | | JAMES J. JAMES | | JAMES J. JAMES | | JAMES J. JAMES | | JAMES J. JAMES | | JAMES J. JAMES | | JAMES J. JAMES | |
| DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | | CITY | | COUNTY | | STATE | | DATE OF DEATH | | TIME OF DEATH | | PLACE OF DEATH | |
| JAN 10 1920 | | 10:00 AM | | HOME | | NEW YORK | | NEW YORK | | NEW YORK | | JAN 10 1920 | | 10:00 AM | | HOME | |

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A JUDGE OF THE SUPREME COURT OF THE STATE OF NEW YORK.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

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VR A15 (4)
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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 11115 | | | | | | | | | | | |
| 11106 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | | | |
| c. LENGTH OF STAY IN 1b
4 days | | | | | | d. STREET ADDRESS
2549 McCulloh Street | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | | | | | a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
FRANK | | | First
N. | | | Middle
JACKSON | | | Last | | |
| 5. SEX
Male | | | 6. COLOR OR RACE
Negro | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 8. DATE OF BIRTH
February 21, 1911 | | |
| 9. AGE (In years last birthday)
50 yrs. | | | IF UNDER 1 YEAR
Months Days | | | IF UNDER 24 HRS.
Hours Min. | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Shipping Clerk | | |
| 11b. KIND OF BUSINESS OR INDUSTRY
Dress Factory | | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | |
| 13. FATHER'S NAME
William Jackson | | | | | | 14. MOTHER'S MAIDEN NAME
Bertha Jackson | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
YES WWII | | | | | | 17. INFORMANT
Clinical Records, VAH, Baltimore, Maryland - Ft. Howard Division | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS GENERALIZED
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
18 MONTHS
UNKNOWN | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (this hospital) attended the deceased from October 24, 1961 to October 28, 1961, that (we) last saw the deceased alive on October 28, 1961, and that death occurred at 11:00 PM from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
M. Lawrence Rubin, M.D. | | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22b. DATE SIGNED
11/29/61 | | |
| 22c. PHYSICIAN'S NAME (Type)
M. LAWRENCE RUBIN, M.D. | | | | | | 22d. ADDRESS
VAH, BALTO. MD. FT HOWARD DIVISION | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE THEREOF
Nov 1, 1961 | | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | | 23d. LOCATION (City, town or county) (State)
BALTIMORE 28, Md. | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Joseph L. Russ | | | | | | ADDRESS
2222 W. North Ave.
Baltimore, Md. | | | 25a. REC'D BY REGISTRAR
DATE
OCT 31 '61 | | |
| 25b. REGISTRAR'S SIGNATURE
William S. Thomas | | | | | | | | | | | |

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[Handwritten signature]

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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
5M 7/59

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(I)

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard | | | | c. LENGTH OF STAY IN 1b 1 Hour | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | | | d. STREET ADDRESS 2924 Riggs Avenue | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Fred -- Jackson | | | | 4. DATE OF DEATH October 19 19 61 | | | | 5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH April 7, 1895 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY Chemical Company York Co., So. Carolina | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Unknown Major Jackson | | | | 14. MOTHER'S MAIDEN NAME Unknown Jannie Williams | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-1 16. SOCIAL SECURITY NO. 246-22-3073 17. INFORMANT Address Clin Rec VAH Baltimore Md - Ft Howard Division | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia
575X DUE TO Peri rectal Abscess
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 1-4 days | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Jack C. Collins | | | | M.D. Jack C. Collins | | | | DATE SIGNED 10-19-61 | | | |
| EXAMINER'S NAME (Type) Jack C. Collins | | | | M.D. M.D. | | | | Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 10-22-61 | | 22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. | | 22d. LOCATION (City, town, or country) Baltimore | | (State) 28, Maryland | |
| 23. FUNERAL DIRECTOR Charles G. Cooper | | | | ADDRESS 512 Carrollton Avenue | | | | 24a. REC'D BY REGISTRAR DATE OCT 24 '61 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Evans | |

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Director, National Security Agency
Washington, D. C. 20505
Subject: [Illegible]
Reference: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11117

CERTIFICATE OF DEATH

11108

| | | | |
|--|------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>-</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>SHADY NOOK HOME</u> | | d. STREET ADDRESS
<u>4001 FREDERICK AVE</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>CLARA L.</u> Middle <u>JARBOE</u> Last <u>-</u> | | 4. DATE OF DEATH
Month <u>10</u> Day <u>21</u> Year <u>1961</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>JULY 15, 1880</u> |
| 9. AGE (In years last birthday)
<u>81</u> yrs. | | IF UNDER 1 YEAR
Months <u>-</u> Days <u>-</u> | IF UNDER 24 HRS.
Hours <u>-</u> Min. <u>-</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>VICE-PRES.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>MOVING BUS.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>-</u> | |
| 13. FATHER'S NAME
<u>MICHAEL KAISER</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARY VAETH</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<u>-</u> | | 16. SOCIAL SECURITY NO.
<u>-</u> | |
| 17. INFORMANT
<u>George H. Jarboe Jr. - 4001 Frederick Ave</u> | | Address
<u>-</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
443 X DUE TO (b) <u>Hypertensive Cardio Vascular</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c) <u>Disease with many Cerebral Thrombi</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 days</u>
<u>10 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>-</u> | | | |
| 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>-</u> | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>-</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>-</u> | | 20f. (City or town) (County) (State)
<u>BALTO</u> <u>MD</u> <u>MD</u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/21</u> 19 <u>61</u> to <u>10/21</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/21</u> 19 <u>61</u> and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Elmer W. Jarboe</u> | | 22b. DATE SIGNED
<u>10/21/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS
<u>3432 Indebity Lane</u>
<u>Baltimore 29, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>10-25-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Cathedral Cem.</u> | | 23d. LOCATION (City, town or county) (State)
<u>Balto</u> <u>MD</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Forley-Corranough, J.H.</u> | | 25a. REC'D BY REGISTRAR
<u>OCT 27 '61</u> | |
| ADDRESS
<u>Catonville, Md.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | |

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Received of the
Hon. Secy. of the Navy
for the sum of \$100.00
on account of the
purchase of the
U.S.S. Albatross

10/10/11

10/10/11

John A. King

John A. King

10/10/11

10/10/11

CERTIFICATE OF DEATH

Reg. Dist. No.

11109

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| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Overlea | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Overlea | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
4233 Cardwell Ave. | | d. STREET ADDRESS
4233 Cardwell Ave. | |
| 3. NAME OF DECEASED (Type or print)
First Carl Middle H. Last Jones | | 4. DATE OF DEATH
Month October Day 20 Year 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 3, 1891 |
| 9. AGE (In years last birthday) yrs.
70 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Tax Assessor | | 10b. KIND OF BUSINESS OR INDUSTRY
Balto. Co. Md. | |
| 11. BIRTHPLACE (State or foreign country)
Balto. Co. Md. | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
William H. Jones | | 14. MOTHER'S MAIDEN NAME
Bertha E. Bishop | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes W W # 1 | | 16. SOCIAL SECURITY NO.
213-20-4210 | |
| 17. INFORMANT
Mrs. Edna E. Jones | | Address
4233 Cardwell Ave. 6 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular many years
422.1 DUE TO Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized Arteriosclerosis
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
11 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10-31 , 19 58 , to 10-20 , 19 61 , that I last saw the deceased alive on 10-19 , 19 61 , and that death occurred at 5:20 P.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Max R. English M.D. | | ADDRESS (Street, city or town, state) 5713 Belair Road DATE SIGNED 10/21/61 | |
| PHYSICIAN'S NAME (Type) Max R. English, M.D. | | Baltimore-6, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10-23-1961 | 22c. NAME OF CEMETERY OR CREMATORY
Baltimore | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Lessahn Funeral Home | | ADDRESS
7401 Belair Rd. | |
| 24a. REC'D BY REGISTRAR
DATE OCT 23 '61 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Harris | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11119

CERTIFICATE OF DEATH

11110

| | | | | | | | |
|---|---------------------------|--|---------------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shady Nook Conv. Home</u> | | | | d. STREET ADDRESS <u>2001 N. Rolling Rd.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>JENNIE LEE KALB</u> | | | | 4. DATE OF DEATH <u>Oct. 28</u> 19 <u>61</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/31/76</u> | | 9. AGE (In years last birthday) <u>85</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James P. Moore</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Martha Horn</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Edgar A. Kalb</u> Address | |
| 18. CAUSE OF DEATH (Enter only one causa par line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-vascular Disease</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 yrs</u> | |
| 20c. TIME OF INJURY
Hour e.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that (I) <u>(this person)</u> attended the deceased from <u>Sept.</u> <u>1951</u> to <u>Oct.</u> <u>1961</u> that (I) <u>see</u> last saw the deceased alive on <u>Oct. 26</u> <u>1961</u> , and that death occurred at <u>1A.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Leo J. Gaver</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>10/29/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u> | | | | 22d. ADDRESS <u>1 Mallow Hill Ave., Baltimore 29, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) (State) | |
| <u>Burial</u> | | <u>Oct. 31, 1961</u> | | <u>Torrance</u> | | <u>Balt. Co. Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>McDonald & Son</u> ADDRESS <u>28</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>NOV 1 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined and within 24 hours after death, page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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are associated with the following items

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | |
|--|--|-----------------------------------|--|--|--|--|--|
| a. COUNTY | | | | a. STATE | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | b. COUNTY | | | |
| c. LENGTH OF STAY IN TB | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | d. STREET ADDRESS | | | |
| e. IS RESIDENCE ON A FARM? | | | | e. IS RESIDENCE ON A FARM? | | | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE | | | |
| a. COUNTY Baltimore | | | | a. STATE Maryland | | | |
| b. CITY OR TOWN Towson | | | | b. COUNTY Baltimore | | | |
| c. LENGTH OF STAY IN TB 3 years 9 Mos. | | | | c. CITY OR TOWN Baltimore, Maryland | | | |
| d. NAME OF HOSPITAL OR INSTITUTION Towson Convalescent Home | | | | d. STREET ADDRESS 1 707 Regester Avenue | | | |
| e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> | | | | e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| First Anna Middle F. Last Kamps | | | | Month October Day 24 Year 1961 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | December 2, 1878 | | 9. AGE (In years last birthday) 82 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| Sales Clerk | | Retail Sales | | Maryland | | U.S.A. | |
| 13. FATHER'S NAME Gerrit Kamps | | | | 14. MOTHER'S MAIDEN NAME Elise Soth | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. F. Kamps, 707 Regester Ave., Balto., Md. | | | |
| 17. INFORMANT F. Kamps, 707 Regester Ave., Balto., Md. | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c)) | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.00 Cardiac Failure | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis | | | | | | | |
| (a), stating the underlying cause last. (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 10, 1960 to Oct 24, 1961 , that (I) (we) last saw the deceased alive on Oct 24, 1961 , and that death occurred at 5:45 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Laurence C. Post | | | | 22b. DATE SIGNED 10/24/61 | | | |
| 22c. PHYSICIAN'S NAME (Type) LAURENCE C. POST | | | | 22d. ADDRESS 6805 YORK RD Baltimore Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 10/26/1961 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gardens | | | | 23d. LOCATION (City, town or county) (State) Balto. Co., Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. | | | | 25a. REC'D BY REGISTRAR OCT 24 '61 | | | |
| ADDRESS 4905 York Rd. Balto. 12, Md. | | | | 25b. REGISTRAR'S SIGNATURE William S. Kneiss | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11112

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Dundalk</u> | | c. LENGTH OF STAY IN 1b
<u>life</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>3468 Dunran Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Jean</u> Middle <u>Y.</u> Last <u>Kapcsos</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>3</u> Year <u>1961</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 14, 1921</u> |
| 9. AGE (In years lost birthday)
<u>40</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>at home</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Jesse Flair</u> | | 14. MOTHER'S MAIDEN NAME
<u>Orpha Buttermen</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u> </u> | |
| 17. INFORMANT
<u>John P. Kapcsos, 3468 Dunran Rd., Balto 22, Md.</u> | | Address
<u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic Myelogenous Leukemia</u>
204.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO
(c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 27, 1961</u> to <u>Oct 1</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Oct 10</u> , 19 <u>61</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Antonio A. de la Fuente</u> | | 22b. DATE SIGNED
<u>October 4, 1961</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>ANTONIA A. de la FUENTE</u> | | 22d. ADDRESS
<u>Maryland General Hospital</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | 23b. DATE THEREOF
<u>10-6-61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Baltimore National</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Catonsville, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Ullrich Funeral Home, Dundalk, Maryland</u> | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 6 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hume</u> | | | |

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Chronic Myelogenous Leukemia

CHRONIC MYELOID LEUKEMIA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11122

CERTIFICATE OF DEATH

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| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN 1b 122 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 5601 Plymouth Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Milton
First Middle Last
4. DATE OF DEATH October 1 19 61
Month Day Year | | 5. SEX Male
6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH January 1 1914
yrs. 47
9. AGE (In years last birthday) 47 yrs.
IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receiving Clerk
10b. KIND OF BUSINESS OR INDUSTRY Leather Goods Store Baltimore Maryland
11. BIRTHPLACE (County & State, or foreign country) U.S.A.
12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Lawrence Kasiura
14. MOTHER'S MAIDEN NAME Mary Borsukiewicz | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes give year or dates of service) WW-11
16. SOCIAL SECURITY NO. WW-11
17. INFORMANT Clin Rec VAH Baltimore Md Ft Howard Division
Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 592X GLOMERULONEPHRITIS, CHRONIC
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 592X DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus; Hypertensive Cardiovascular Disease; Thrombosis of right middle Cerebral Artery; Infected Decubiti
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. TIME OF INJURY Month, Day, Year 19 61
Hour a.m. p.m.
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Baltimore (County) Maryland (State) | | 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 1 1961 to Oct 1 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct 1 1961 , and that death occurred at 5:00 P.M. from the causes and on the date stated above. | |
| 22a. SIGNATURE C. M. Snyder M.D.
22c. PHYSICIAN'S NAME (Type) C. M. Snyder M.D.
22d. ADDRESS VAH Balto Md - Ft Howard Division | | 22b. DATE SIGNED 10-1-61
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Oct 5-1961
23c. NAME OF CEMETERY OR CREMATORY Holy Rosary
23d. LOCATION (City, town or county) Baltimore (State) Maryland | | 24. FUNERAL DIRECTOR'S SIGNATURE Fred W Ozazewski
25a. REC'D BY REGISTRAR DATE OCT 4 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11123

CERTIFICATE OF DEATH

11114

Item 9 Film G297 10/11/61 iwk

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | |
| a. COUNTY
<i>Baltimore</i> | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Lutherville</i> | | a. STATE
<i>MD.</i> | | b. COUNTY
<i>—</i> | |
| c. LENGTH OF STAY IN 1b
<i>19 days</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Baltimore</i> | | d. STREET ADDRESS
<i>1308 Argonne</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>College Manor</i> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| First <i>Maggie</i> Middle <i>E.</i> Last <i>Keese</i> | | | | Month <i>10</i> Day <i>5</i> Year <i>1961</i> | | | |
| 5. SEX
<i>Female</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>10-29-1874</i> | |
| 9. AGE (In years last birthday)
<i>86 yrs.</i> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>House wife</i> | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Baltimore</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Oscar Marks</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Harriet Hansen</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
<i>Mr. J. Keller K.H.</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
<i>metastatic carcinoma</i> | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>199X</i>
DUE TO (b) <i>199X</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>199X</i>
DUE TO (c) <i>199X</i> | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>weeks</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>199X</i> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour a.m. <i>19</i> p.m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>9-21-61</i>, 19<i>61</i>, to <i>Oct 5</i>, 19<i>61</i>, that (I) (we) last saw the deceased alive on <i>Oct 5</i>, 19<i>61</i>, and that death occurred at <i>11:45</i> AM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Ernest C. Brown Jr.</i> | | | | 22b. DATE SIGNED
<i>10-9-61</i> | | 22c. PHYSICIAN'S NAME (Type)
<i>Ernest C. Brown, Jr.</i> | |
| 22d. ADDRESS
<i>1101 N. Calvert St. Balt 2 Md.</i> | | | | 22e. REC'D BY REGISTRAR
<i>Arthur S. Hume</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE THEREOF
<i>10/9/61</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>BALTIMORE</i> | | 23d. LOCATION (City, town or county) (State)
<i>BALTIMORE MD.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>L. J. Ruck</i> | | | | 25. REGISTRAR'S SIGNATURE
<i>Arthur S. Hume</i> | | | |

TO: **FATAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN 1b 3yr7mth9dys
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bel Air, Maryland
d. STREET ADDRESS 625 Roland Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First Julia Middle Marie Last Kelly | | | 4. DATE OF DEATH
Month OCT. Day 14 Year 1961 | | | | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 25, 1906 | | 9. AGE (In years last birthday) 55 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher | | 10b. KIND OF BUSINESS OR INDUSTRY Public Schools | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME John Kelly | | | 14. MOTHER'S MAIDEN NAME Julia Larner | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16. SOCIAL SECURITY NO. 220-24-2883 | | 17. INFORMANT (Sister) Mrs. Helen Kelly Address 625 Roland Ave., Bel Air, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LOBAR PNEUMONIA.
DUE TO 490X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| 20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
et work et work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that he (this hospital) attended the deceased from March 4, 1958 , to 10/14, 1961 , that (I) (we) last saw the deceased alive on Oct. 14, 1961 , and that death occurred at 3:15 A.M. from the causes and on the date stated above. | | | | | | | | | |
| 22e. SIGNATURE Jose R. Arizaga M.D. | | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type) JOSE R. ARIZAGA | | | | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Oct. 16, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL GARDENS | | 23d. LOCATION (City, town or county) (State) BEL AIR, Harford Co., Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway + Williams St. BEL AIR, Maryland | | | | | 25a. REC'D BY REGISTRAR DCI 16 '61 | | 25b. REGISTRAR'S SIGNATURE Joseph W. Foster | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11116

11125

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore (Relay, Md.) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore (Relay, Md.) | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1719 Sutton Avenue | | | | e. STREET ADDRESS
1719 Sutton Ave. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Ellen Middle R. Last Kennedy | | | | 4. DATE OF DEATH
Month Oct. Day 3, Year 1961 | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 13, 1866 | |
| 9. AGE (In years lost birthday)
94 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
Peter J. Brookey | | | | 14. MOTHER'S MAIDEN NAME
Ellen Ford | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT Address
Albert A. Kennedy, Sr. 1804 Woodside Ave. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis
420-1 DUE TO (b) Atherosclerotic C.V. Disease
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 HOUR
15 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1955 to Oct 3, 1961, that (I) (we) last saw the deceased alive on Sept 21, 1961, and that death occurred at 11:40 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
John F. Coolahan | | | | 22b. ADDRESS
4201 Wilkens Avenue #29 | | 22c. DATE SIGNED
10/4/61 | |
| 22c. PHYSICIAN'S NAME (Type)
John Coolahan, M.D. | | | | 22d. ADDRESS
4201 Wilkens Avenue #29 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/7/61 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23d. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Howard H. Hubbard | | | | 25a. REC'D BY REGISTRAR
DATE OCT 5 '61 | | 25b. REGISTRAR'S SIGNATURE
William L. House | |

TO HO... OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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WHITEHALL OF DEATH

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(M)

William (Hill, H.)

William (Hill, H.)

1111 Jackson Avenue

1111 Jackson Avenue

Ellen

Ellen

Oct. 11

Female

Nov. 11, 1890

Nov. 11, 1890

Nov. 11, 1890

Robert

Id.

Peter J. Hickey

Ellen Ford

none

Albert A. Kennedy

Albert A. Kennedy

William (Hill, H.)

John Goodrich, M.D.

John Goodrich, M.D.

John Goodrich, M.D.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11126

CERTIFICATE OF DEATH

11117

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|---|----------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
1mth17dys | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS
338 Greenlow Road | | a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Susan B. Kennedy | | | 4. DATE OF DEATH
Month October Day 29 Year 61 | | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 2, 1885 | | 9. AGE (In years last birthday)
76yrs. | IF UNDER 1 YEAR
Months 1 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
XXXXXX | | 11. BIRTHPLACE (County & State, or foreign country)
XXXXXX Va. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
XXXXXX Milton Orndorff | | | 14. MOTHER'S MAIDEN NAME
XXXXXX Kissiah Linderman | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
Address Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pleural Effusion
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Congestive heart failure
DUE TO
(c) Arteriosclerotic heart disease | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour a.m. 19
p.m. | Month, Day, Year | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 21. I certify that (a) (this hospital) attended the deceased from Aug. 15, 1961 , to Oct. 2, 1961 , that (I) (we) last saw the deceased alive on Oct. 2, 1961 , and that death occurred at 10:20 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Stella Wachslar M.D. | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
10-2-61 | | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachslar, M. D. | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Catonsville 28, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/5/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Howard H. Hubbard | | | ADDRESS
4107 Wilkens Avenue | | 25a. REC'D BY REGISTRAR
OCT 5 '61 | | 25b. REGISTRAR'S SIGNATURE
Charles E. Thomas |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(1)

Neward H. Hubbard 4107 Wilkins Avenue
Baltimore, Maryland
10/5/51

London Park Cemetery, Baltimore, Maryland

1885 7675.

XXXXXX Kissiah Linderman

XXXXXX Milton Gimborty

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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| | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u>
c. LENGTH OF STAY IN 1b
<u>241 RIDGEWAY RD.</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>241 RIDGEWAY RD.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u>
d. STREET ADDRESS
<u>241 RIDGEWAY RD.</u>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>ROBERT R. KIRBY</u> | | 4. DATE OF DEATH
Month Day Year
<u>OCT. 10, 1961</u> | | 5. SEX
<u>M</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>DEC. 26, 1892</u> | | 9. AGE (In years last birthday) <u>68</u> yrs.
IF UNDER 1 YEAR: Months _____ Days _____
IF UNDER 24 HRS.: Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>PRINTER-RET. SELF-EMP.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>MD.</u> | | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>MD.</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>MD.</u> | | | |
| 13. FATHER'S NAME
<u>HOWARD KIRBY</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>ELLA</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>INTS. Robert R. Kirby - 241 Ridgeway Rd.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatous</u>
<u>155.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of Bil Ducts</u>
(c) <u>2 yrs.</u>
(e), stating the underlying cause last. | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 yrs.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 10, 1961</u> to <u>Oct. 10, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct. 10, 1961</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
<u>J. Nelson McKay</u> M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED
<u>10/11/61</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>J. NELSON MCKAY</u> | | | | 22d. ADDRESS
<u>6014 EDMONDSON AVE</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | 23b. DATE THEREOF
<u>10-13-61</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cathedral Em.</u> | | | | 23d. LOCATION (City, town or county) <u>Balto.</u> (State) <u>MD</u> | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>July - Cunningham - Catonsville Md</u> ADDRESS | | | | | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR
DATE <u>OCT 16 '61</u> | | | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur L. Thomas</u> | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11128

CERTIFICATE OF DEATH

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| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>209 Ridgefield Road</u> | | d. STREET ADDRESS
<u>209 Ridgefield Road</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Mr. John Charles Kirchner</u> | | 4. DATE OF DEATH
Month <u>October</u> Day <u>27th</u> Year <u>1961</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 3, 1899</u> |
| 9. AGE (In years last birthday)
<u>62</u> | | 10. AGE (In years last birthday)
<u>62</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Self Employed</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Adt.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Edward Kirchner</u> | | 14. MOTHER'S MAIDEN NAME
<u>Pauline Schaefer</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>212-07-7547</u> | |
| 17. INFORMANT
<u>Mrs. Sophia Kirchner</u> | | Address
<u>same</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CORONARY ARTERY OCCLUSION</u>
DUE TO (b) <u>CORONARY ARTERY DISEASE</u>
DUE TO (c) <u>420.1</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
<u>IMMEDIATE</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>CORONARY ARTERY OCCLUSION MYOCARDIAL INFARCTION 6/1/61</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/30</u> , 19 <u>61</u> , to <u>10/27</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10/16</u> , 19 <u>61</u> , and that death occurred at <u>2:25</u> P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>T. C. Siwinski</u> | | 22b. DATE
<u>10/27/61</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>T. C. Siwinski, M.D.</u> | | 22d. ADDRESS
<u>206 W. Pennsylvania Avenue, Towson 4, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>10/30/61</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer Cem.</u> | 23d. LOCATION (City, town or county) (State)
<u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Rack</u> | | 25a. REC'D BY REGISTRAR
<u>OCT 30 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Frank</u> | | | |

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RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11129

CERTIFICATE OF DEATH

11120

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| c. LENGTH OF STAY in 1b
54 Days | | d. STREET ADDRESS
3615 Keystone Avenue | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
WALTER H. KLOPP | | 4. DATE OF DEATH
Month Oct. Day 15 Year 19 61 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 29, 1880 |
| 9. AGE (In years last birthday)
81 yrs. | | 10. IF UNDER 1 YEAR
Months 0 Days 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Berks County, Pennsylvania | |
| 11. BIRTHPLACE (County & State, or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Henry Klopp | | 14. MOTHER'S MAIDEN NAME
Sarah Burger | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
YES SAW | | 16. SOCIAL SECURITY NO.
213-10-1797 | |
| 17. INFORMANT
Clin Rec VAH Baltimore Md Ft Howard Division | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL FIBROSIS
DUE TO
CORONARY ARTERIOSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. LEFT LOWER LOBE PNEUMONIA
INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN
UNKNOWN
2 DAYS + | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Nephrosclerosis | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 22, 1961 to Oct. 15, 1961 that (we) last saw the deceased alive on Oct 15, 1961 , and that death occurred at 5:25 p.m. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
SEBASTIAN RUSSO, M.D. | | 22b. DATE SIGNED
10-16-61 | |
| 22c. PHYSICIAN'S NAME (Type)
SEBASTIAN RUSSO, M.D. | | 22d. ADDRESS
VAH Baltimore Md - Ft Howard Division | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct. 19, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery Baltimore Maryland | | 23d. LOCATION (City, town or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook-Blight Inc | | 25a. REC'D BY REGISTRAR
ACT 17 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Huns | | | |

M

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Mr. Geo. Wright, Inc.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11121

11130

| | | | | | | | |
|---|----------------------------------|---|--|--|---|---|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY BALTIMORE <small>MARYLAND</small> | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE MD b. COUNTY 3 V01-4 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
1148 hrs 8 day | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Maryland | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Spring Grove State Hospital | | | | d. STREET ADDRESS
707 N Duncan St. Baltimore | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Anna Middle Korecky Last Korecky | | | | 4. DATE OF DEATH
Month 10 Day 15 Year 61 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 27, 1877 | | 9. AGE (In years last birthday)
84 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
tailor | | 10b. KIND OF BUSINESS OR INDUSTRY
Skrabek's | | 11. BIRTHPLACE (State or foreign country)
Braka, Bohemia | | 12. CITIZEN OF WHAT COUNTRY?
Bohemia <input checked="" type="checkbox"/> | |
| 13. FATHER'S NAME
unknown | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
unknown | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
Address Records: Spring Grove State Hospital | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
450.00 IMMEDIATE CAUSE (a) Dehydration and inanition
DUE TO Due to
Generalized arteriosclerosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE Geo. S. M. Kieffer | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED | |
| EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/18/61 | | 22c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cem. | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles E. Schimunek
ADDRESS
3331 Brehms Lane | | | | 24a. REC'D BY REGISTRAR
OCT 17 '61 | | 24b. REGISTRAR'S SIGNATURE
William S. Hanes | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11131

11122

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN 1b 11 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland
f. COUNTY Baltimore
g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 31
h. STREET ADDRESS 1826 Gough Street
i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
First GEORGE Middle --- Last KRUG | | | | 4. DATE OF DEATH
Month October Day 3 Year 1961 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
March 4, 1894 | | 9. AGE (In years last birthday) 67 yrs.
IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic
10b. KIND OF BUSINESS OR INDUSTRY Garage | | | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
George Krug | | | | 14. MOTHER'S MAIDEN NAME
Jennie Darmstead | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW I | | | | 16. SOCIAL SECURITY NO.
214-05-3813 | | 17. INFORMANT
Clinical Records, VAH, Baltimore 18, Maryland
FORT HOWARD DIVISION | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) THROMBOSIS OF BASILAR ARTERY
DUE TO (b) CEREBRAL ARTERIOSCLEROSIS
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year 19
Hour a.m. 4:25
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (X) (this hospital) attended the deceased from September 22, 1961 to October 3, 1961 , that (we) last saw the deceased alive on Oct. 3, 1961 , and that death occurred at P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
 | | | | 22b. DATE SIGNED
10/4/61 | | 22c. PHYSICIAN'S NAME (Type)
SEBASTIAN RUSSO, M.D. | | | |
| 22d. ADDRESS
VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION | | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-6-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore 28, Maryland | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14, Md. | | | | 25a. REC'D BY REGISTRAR (Type) OCT 10 1961
25b. REGISTRAR'S SIGNATURE
 | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

11135

11135

(M)

Veterans Administration Hospital
11135
October 3, 1945

October 3, 1945
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October 3, 1945

October 3, 1945
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October 3, 1945

October 3, 1945
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October 3, 1945
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October 3, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11132

CERTIFICATE OF DEATH

11123

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b
Catonsville 45yr3mth28dys Baltimore
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SPRING GROVE STATE HOSPITAL 2238 East Baltimore St. | | | | 2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission)
a. STATE Maryland b. COUNTY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS
3121-4
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Bessie Lahey | | | 4. DATE OF DEATH
Month Day Year
October 1 19 61 | | | | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> July 19, 1898 | | | |
| 9. AGE (In years last birthday)
63 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
none | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
James Lahey | | 14. MOTHER'S MAIDEN NAME
Mathilda Walters | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No unknown | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
Address
Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) Acute Occlusion of the Coronary Artery (sudden)</p> <p>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.</p> <p>(b) Hypertensive Arteriosclerotic Heart Disease</p> <p>(c) Generalized Arteriosclerosis, with Hypertension</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> <p>Diabetes Mellitus</p> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
none | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. none 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none | | | |
| 20f. (City or town)
none | | 20g. (County)
none | | 20h. (State)
none | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 1, 1916 to October 1, 1961 , that (I) (we) last saw the deceased alive on October 1, 1961 , and that death occurred at 9:15 AM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Imre KOPITS, M.D. | | 22b. DATE SIGNED
9:15 AM | | 22c. PHYSICIAN'S NAME (Type)
Imre KOPITS, M.D. | | | |
| 22d. ADDRESS
SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | |
| 23b. DATE THEREOF
10-4-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Oaklawn Cemetery Essex, Md. | | 23d. LOCATION (City, town or county)
Essex, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. J. Tickner & Sons Baltimore 17, Md. | | 25a. REC'D BY REGISTRAR
DATE OCT 3 '61 | | 25b. REGISTRAR'S SIGNATURE
Claring S. Hume | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

11183

11183

(M)

(1)

U.S. National Archives
10-1-61
10-1-61
10-1-61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11133

11124

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonville 28
c. LENGTH OF STAY in 1b 7-30-1957
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Caton, Bridge Nursing Home, 329 Harlem Avenue | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland
f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lansdowne (Baltimore Co.)
d. STREET ADDRESS Third Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) George P. Lathe | | 4. DATE OF DEATH
Month October Day 11 Year 19 61 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 5, 1885 |
| 9. AGE (In years last birthday) 75 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Glass Blower | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Gene Lathe | |
| 14. MOTHER'S MAIDEN NAME Stella (unknown) | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No | |
| 16. SOCIAL SECURITY NO. 219-07-2305 A | | 17. INFORMANT George W. Lathe Address 5450 Cedonia Avenue | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease
DUE TO (c) Age | | INTERVAL BETWEEN ONSET AND DEATH
2 weeks
Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) None | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. 19
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7-30-1957 , 19....., to 10-11-1961 , 19....., that (I) (we) last saw the deceased alive on 10-9-1961 , 19....., and that death occurred at 5:30M , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Cliff Ratliff, Jr. M.D. | | 22b. DATE SIGNED 10-11-61 | |
| 22c. PHYSICIAN'S NAME (Type) Cliff Ratliff, Jr. M.D. | | 22d. ADDRESS 4605 Edmondson Avenue, Baltimore 29, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Oct. 14, 1961 | 23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem. | 23d. LOCATION (City, town or county) (State) Baltimore, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook, Inc., 1217 St. Paul Street, Zone 2 | | 25a. REC'D BY REGISTRAR
DATE OCT 13 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Hwang | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1990-1991

Casey, John J. 1910-1911

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CONFIDENTIAL

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510-07-2302 A George A. Latta

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STATE DEPT., WASH., D.C.

Marine Oct. 10, 1961 St. Peter's Bay.

Dr. J. H. Moore, Jr., M.D.

2000, 1999, 1998, 1997, 1996, 1995, 1994, 1993, 1992, 1991, 1990, 1989, 1988, 1987, 1986, 1985, 1984, 1983, 1982, 1981, 1980, 1979, 1978, 1977, 1976, 1975, 1974, 1973, 1972, 1971, 1970, 1969, 1968, 1967, 1966, 1965, 1964, 1963, 1962, 1961, 1960, 1959, 1958, 1957, 1956, 1955, 1954, 1953, 1952, 1951, 1950, 1949, 1948, 1947, 1946, 1945, 1944, 1943, 1942, 1941, 1940, 1939, 1938, 1937, 1936, 1935, 1934, 1933, 1932, 1931, 1930, 1929, 1928, 1927, 1926, 1925, 1924, 1923, 1922, 1921, 1920, 1919, 1918, 1917, 1916, 1915, 1914, 1913, 1912, 1911, 1910, 1909, 1908, 1907, 1906, 1905, 1904, 1903, 1902, 1901, 1900, 1899, 1898, 1897, 1896, 1895, 1894, 1893, 1892, 1891, 1890, 1889, 1888, 1887, 1886, 1885, 1884, 1883, 1882, 1881, 1880, 1879, 1878, 1877, 1876, 1875, 1874, 1873, 1872, 1871, 1870, 1869, 1868, 1867, 1866, 1865, 1864, 1863, 1862, 1861, 1860, 1859, 1858, 1857, 1856, 1855, 1854, 1853, 1852, 1851, 1850, 1849, 1848, 1847, 1846, 1845, 1844, 1843, 1842, 1841, 1840, 1839, 1838, 1837, 1836, 1835, 1834, 1833, 1832, 1831, 1830, 1829, 1828, 1827, 1826, 1825, 1824, 1823, 1822, 1821, 1820, 1819, 1818, 1817, 1816, 1815, 1814, 1813, 1812, 1811, 1810, 1809, 1808, 1807, 1806, 1805, 1804, 1803, 1802, 1801, 1800, 1799, 1798, 1797, 1796, 1795, 1794, 1793, 1792, 1791, 1790, 1789, 1788, 1787, 1786, 1785, 1784, 1783, 1782, 1781, 1780, 1779, 1778, 1777, 1776, 1775, 1774, 1773, 1772, 1771, 1770, 1769, 1768, 1767, 1766, 1765, 1764, 1763, 1762, 1761, 1760, 1759, 1758, 1757, 1756, 1755, 1754, 1753, 1752, 1751, 1750, 1749, 1748, 1747, 1746, 1745, 1744, 1743, 1742, 1741, 1740, 1739, 1738, 1737, 1736, 1735, 1734, 1733, 1732, 1731, 1730, 1729, 1728, 1727, 1726, 1725, 1724, 1723, 1722, 1721, 1720, 1719, 1718, 1717, 1716, 1715, 1714, 1713, 1712, 1711, 1710, 1709, 1708, 1707, 1706, 1705, 1704, 1703, 1702, 1701, 1700, 1699, 1698, 1697, 1696, 1695, 1694, 1693, 1692, 1691, 1690, 1689, 1688, 1687, 1686, 1685, 1684, 1683, 1682, 1681, 1680, 1679, 1678, 1677, 1676, 1675, 1674, 1673, 1672, 1671, 1670, 1669, 1668, 1667, 1666, 1665, 1664, 1663, 1662, 1661, 1660, 1659, 1658, 1657, 1656, 1655, 1654, 1653, 1652, 1651, 1650, 1649, 1648, 1647, 1646, 1645, 1644, 1643, 1642, 1641, 1640, 1639, 1638, 1637, 1636, 1635, 1634, 1633, 1632, 1631, 1630, 1629, 1628, 1627, 1626, 1625, 1624, 1623, 1622, 1621, 1620, 1619, 1618, 1617, 1616, 1615, 1614, 1613, 1612, 1611, 1610, 1609, 1608, 1607, 1606, 1605, 1604, 1603, 1602, 1601, 1600, 1599, 1598, 1597, 1596, 1595, 1594, 1593, 1592, 1591, 1590, 1589, 1588, 1587, 1586, 1585, 1584, 1583, 1582, 1581, 1580, 1579, 1578, 1577, 1576, 1575, 1574, 1573, 1572, 1571, 1570, 1569, 1568, 1567, 1566, 1565, 1564, 1563, 1562, 1561, 1560, 1559, 1558, 1557, 1556, 1555, 1554, 1553, 1552, 1551, 1550, 1549, 1548, 1547, 1546, 1545, 1544, 1543, 1542, 1541, 1540, 1539, 1538, 1537, 1536, 1535, 1534, 1533, 1532, 1531, 1530, 1529, 1528, 1527, 1526, 1525, 1524, 1523, 1522, 1521, 1520, 1519, 1518, 1517, 1516, 1515, 1514, 1513, 1512, 1511, 1510, 1509, 1508, 1507, 1506, 1505, 1504, 1503, 1502, 1501, 1500, 1499, 1498, 1497, 1496, 1495, 1494, 1493, 1492, 1491, 1490, 1489, 1488, 1487, 1486, 1485, 1484, 1483, 1482, 1481, 1480, 1479, 1478, 1477, 1476, 1475, 1474, 1473, 1472, 1471, 1470, 1469, 1468, 1467, 1466, 1465, 1464, 1463, 1462, 1461, 1460, 1459, 1458, 1457, 1456, 1455, 1454, 1453, 1452, 1451, 1450, 1449, 1448, 1447, 1446, 1445, 1444, 1443, 1442, 1441, 1440, 1439, 1438, 1437, 1436, 1435, 1434, 1433, 1432, 1431, 1430, 1429, 1428, 1427, 1426, 1425, 1424, 1423, 1422, 1421, 1420, 1419, 1418, 1417, 1416, 1415, 1414, 1413, 1412, 1411, 1410, 1409, 1408, 1407, 1406, 1405, 1404, 1403, 1402, 1401, 1400, 1399, 1398, 1397, 1396, 1395, 1394, 1393, 1392, 1391, 1390, 1389, 1388, 1387, 1386, 1385, 1384, 1383, 1382, 1381, 1380, 1379, 1378, 1377, 1376, 1375, 1374, 1373, 1372, 1371, 1370, 1369, 1368, 1367, 1366, 1365, 1364, 1363, 1362, 1361, 1360, 1359, 1358, 1357, 1356, 1355, 1354, 1353, 1352, 1351, 1350, 1349, 1348, 1347, 1346, 1345, 1344, 1343, 1342, 1341, 1340, 1339, 1338, 1337, 1336, 1335, 1334, 1333, 1332, 1331, 1330, 1329, 1328, 1327, 1326, 1325, 1324, 1323, 1322, 1321, 1320, 1319, 13

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 11125
CERTIFICATE OF DEATH

11134

| | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard
c. LENGTH OF STAY IN TB
64 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 6
d. STREET ADDRESS
Hazelwood Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
JOHN | | First | | Middle
---- | | Last
LATTIK | | 4. DATE OF DEATH
Month
October
Day
24
Year
19 61 | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
February 7, 1890 | | 9. AGE (In years last birthday)
71 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | 10b. KIND OF BUSINESS OR INDUSTRY
Shipping - Shipyards | | 11. BIRTHPLACE (County & State, or foreign country)
Estonia | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
Jon Lattik | | | | 14. MOTHER'S MAIDEN NAME
Mary MN: Unknown | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
WW I 213-01-8819 | | 17. INFORMANT
Address
VAH, Baltimore 18, Maryland, Clinical Records, Fort Howard Division | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) POSTERIOR MYOCARDIAL INFARCTION, RECENT(& OLD)
DUE TO SEVERE CORONARY CALCIFIC SCLEROSIS
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 DAY UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Left Cerebral Encephalomalacia due to Cerebral Arteriosclerosis. Operations: L leg A/K 9/22/61; R leg AK 10/16/61 - Amputations. | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
August 21, 1961 | | 20g. (County)
Howard County, Maryland | |
| 21. I certify that (1) (x) (this hospital) attended the deceased from August 21, 1961 to October 24, 1961 that (2) (we) last saw the deceased alive on October 24, 1961 and that death occurred at 5:00 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Sebastian Russo
M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
10/25/61 | | | |
| 22c. PHYSICIAN'S NAME (Type)
SEBASTIAN RUSSO, M.D. | | | | 22d. ADDRESS
VAH, BALTO. 18 MD. FT. HOWARD, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-28-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Trinity(Orthodox) | | 23d. LOCATION (City, town or county) (State)
Howard County, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14 | | | | 25a. REC'D BY REGISTRAR
OCT 27 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

11-11-41

11-11-41

(M)

Belmont

For Howard

at 10

Belmont

Veterans Administration

John

John

October 25

John

John

February 1, 1942

John

John

John

U.S.A.

(I)

John

John

John

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October 25

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October 25

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1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|-------------------------------------|--|---|--|--|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 11135 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 11126 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | c. LENGTH OF STAY IN 1b | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Middle River</u> | | | | d. STREET ADDRESS
<u>13716 Wilson Point Road</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>William James Lee</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>October 30th 19 61</u> | | | | | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Aug. 26, 1904</u> | | 9. AGE (In years last birthday)
<u>57</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>The Martin Co.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country)
<u>British Isles</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Ralph Lee</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Ann Switzer</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>212-01-3382</u> | | 17. INFORMANT
Address
<u>Mr. George H. Lee 4216 Harford Terrace.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Drowning - accidental</u> | | | | | | | | | | | |
| 929.8 DUE TO | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 25a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 25b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)
<u>Pt. Fell from pier while fishing</u> | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE
<u>Jack C Collins</u> | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED
<u>10-27-61</u> | | | |
| EXAMINER'S NAME (Type)
<u>JACK C Collins</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11/1/61</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Moreland Mem Park</u> | | | | 22d. LOCATION (City, town, or country) (State)
<u>Baltimore, Maryland</u> | | | |
| 23. FUNERAL DIRECTOR
ADDRESS
<u>Leonard J. Ruck 5305 Harford Road #14</u> | | | | 24a. REC'D BY REGISTRAR
DATE
<u>OCT 31 '61</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. House</u> | | | | | |

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11/18/80

11/18/80

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

11136

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11127

| | | | |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i> | | c. LENGTH OF STAY IN 1b <i>67 years</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Western Run Road</i> | | d. STREET ADDRESS <i>Western Run Road</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Zachariah</i> First <i>Lee</i> Middle <i>Lee</i> Last | | 4. DATE OF DEATH <i>14 October</i> 14 1961 | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Colored</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>10 August 1894</i> |
| 9. AGE (In years lost birthday) <i>67</i> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Building</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Western Run Rd. Cockeysville</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>George Edward Lee</i> | | 14. MOTHER'S MAIDEN NAME <i>Emma Mayers</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>World War I</i> | | 16. SOCIAL SECURITY NO. <i>213-12-6330</i> | |
| 17. INFORMANT <i>Wife - Alice Lee</i> | | Address <i>Same</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>
<i>420.1</i> DUE TO <i>A.S.C.V.D.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <i>few minutes</i>
<i>over 15 years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1961</i> to <i>Sept 1961</i> , that (I) (we) lost <i>saw</i> the deceased alive on <i>Sept 1961</i> , and that death occurred on <i>14 Oct 1961</i> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Walter T. Kees</i> | | 22b. DATE SIGNED <i>14 Oct 1961</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i> | | 22d. ADDRESS <i>Cockeysville Md</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>10/18/61</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Lough's</i> | | 23d. LOCATION (City, town, or county) (State) <i>Cockeysville, Balto. Co. Md.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. L. Chatman</i> | | 25a. REC'D BY REGISTRAR <i>16 '61</i> DATE | |
| 25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | | |

1918

CERTIFICATE OF DEATH

11138



MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11121

11121

| | | | | | |
|-----------------------------|--|-------------------------------|--|----------------------------------|--|
| 1. Name of Deceased | | 2. Sex | | 3. Age | |
| 4. Date of Death | | 5. Time of Death | | 6. Place of Death | |
| 7. Cause of Death | | 8. Manner of Death | | 9. Signature of Medical Examiner | |
| 10. Signature of Coroner | | 11. Signature of Registrar | | 12. Signature of Burial Officer | |
| 13. Signature of Undertaker | | 14. Signature of Funeral Home | | 15. Signature of Cemetery | |
| 16. Signature of Church | | 17. Signature of Minister | | 18. Signature of Family | |
| 19. Signature of Friends | | 20. Signature of Neighbors | | 21. Signature of Community | |
| 22. Signature of State | | 23. Signature of Nation | | 24. Signature of World | |
| 25. Signature of Universe | | 26. Signature of God | | 27. Signature of Jesus | |
| 28. Signature of Mary | | 29. Signature of John | | 30. Signature of Peter | |
| 31. Signature of Paul | | 32. Signature of James | | 33. Signature of Joseph | |
| 34. Signature of David | | 35. Signature of Solomon | | 36. Signature of Daniel | |
| 37. Signature of Isaiah | | 38. Signature of Jeremiah | | 39. Signature of Ezekiel | |
| 40. Signature of Micah | | 41. Signature of Habakkuk | | 42. Signature of Zephaniah | |
| 43. Signature of Nahum | | 44. Signature of Habakkuk | | 45. Signature of Zephaniah | |
| 46. Signature of Nahum | | 47. Signature of Habakkuk | | 48. Signature of Zephaniah | |
| 49. Signature of Nahum | | 50. Signature of Habakkuk | | 51. Signature of Zephaniah | |
| 52. Signature of Nahum | | 53. Signature of Habakkuk | | 54. Signature of Zephaniah | |
| 55. Signature of Nahum | | 56. Signature of Habakkuk | | 57. Signature of Zephaniah | |
| 58. Signature of Nahum | | 59. Signature of Habakkuk | | 60. Signature of Zephaniah | |
| 61. Signature of Nahum | | 62. Signature of Habakkuk | | 63. Signature of Zephaniah | |
| 64. Signature of Nahum | | 65. Signature of Habakkuk | | 66. Signature of Zephaniah | |
| 67. Signature of Nahum | | 68. Signature of Habakkuk | | 69. Signature of Zephaniah | |
| 70. Signature of Nahum | | 71. Signature of Habakkuk | | 72. Signature of Zephaniah | |
| 73. Signature of Nahum | | 74. Signature of Habakkuk | | 75. Signature of Zephaniah | |
| 76. Signature of Nahum | | 77. Signature of Habakkuk | | 78. Signature of Zephaniah | |
| 79. Signature of Nahum | | 80. Signature of Habakkuk | | 81. Signature of Zephaniah | |
| 82. Signature of Nahum | | 83. Signature of Habakkuk | | 84. Signature of Zephaniah | |
| 85. Signature of Nahum | | 86. Signature of Habakkuk | | 87. Signature of Zephaniah | |
| 88. Signature of Nahum | | 89. Signature of Habakkuk | | 90. Signature of Zephaniah | |
| 91. Signature of Nahum | | 92. Signature of Habakkuk | | 93. Signature of Zephaniah | |
| 94. Signature of Nahum | | 95. Signature of Habakkuk | | 96. Signature of Zephaniah | |
| 97. Signature of Nahum | | 98. Signature of Habakkuk | | 99. Signature of Zephaniah | |
| 100. Signature of Nahum | | 101. Signature of Habakkuk | | 102. Signature of Zephaniah | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11138

11129

| | | | | | | | |
|---|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CATONSVILLE</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BALTIMORE</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>PARADISE NURSING HOME</u> | | | | d. STREET ADDRESS
<u>2810 HILLCREST AVE #14</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>ALBERT R. LEHMAN</u> | | | | 4. DATE OF DEATH Month Day Year
<u>OCT. 29, 61</u> 19 | | | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>APR 14 8, 1893</u> | | 9. AGE (In years last birthday) yrs.
<u>68</u> | 10. IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired)
<u>ASST. TO AUDITOR</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>BTO R.R.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>?</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>MARY E.</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>—</u> | | 17. INFORMANT Address
<u>MARY E. LEHMAN 2810 HILLCREST AVE.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) <u>199.1</u>
 DUE TO <u>Malignant Tumor Left Shoulder</u>
 (b) <u>Massive & Extensive</u>
 DUE TO <u>(Pathological Sections From Biopsy)</u>
 (c) <u>Ar2 En route</u></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/28/61</u> to <u>10/29/61</u> , that (I) was last saw the deceased alive on <u>10/28/61</u> , and that death occurred <u>PM</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | | | 22b. DATE SIGNED <u>10/30/61</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>W. E. McGroth M.D.</u> | | | | 22d. ADDRESS <u>1303 Frederick Rd (28)</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>NOV. 1, 1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>PARKWOOD</u> | | 23d. LOCATION (City, town, or county) (State)
<u>BALTO., MD.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
<u>Paul E. Charonetzki 3617 Chestnut Ave.</u> | | | | 25a. REC'D BY REGISTRAR
<u>Oct 31 '61</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles S. Hanna</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

WS11

WASH TO TAMPA

REPLY

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11141

11130

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville Manor
c. LENGTH OF STAY IN 1b
MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
5902 Harford Ave. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville Manor
d. STREET ADDRESS
5902 Harford Ave.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Eva M. Lindner | | 4. DATE OF DEATH
Month Oct. Day 31 Year 1961 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 23, 1921 |
| 9. AGE (In years last birthday)
40 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cutter | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Joseph Dailey | |
| 14. MOTHER'S MAIDEN NAME
Catherine Kuester | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO.
212 16 0060 | | 17. INFORMANT
George A. Lindner, 5902 Harford Ave. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 170x Carcinoma of breast, right
DUE TO (b) 2 yrs.
Conditions, if any, which gave rise to immediate cause (c) 170x
DUE TO (c) 170x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
170x | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 1959 to 10/31 , 19 61 , that (I) (was) last saw the deceased alive on 10/30 , 19 61 , and that death occurred at 3 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
D. C. MacLaughlin
M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
D. C. MacLaughlin, M.D. | | 22d. ADDRESS
4508 Edmondson Village Baltimore 29, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Nov. 3/61 | 23c. NAME OF CEMETERY OR CREMATORY
London Park | 23d. LOCATION (City, town or county) (State)
Baltimore 29, Md. |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Witzke F.D. 4101 | | 25a. REC'D BY REGISTRAR
NOV 1 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Charles L. Hanna | | | |

06111

11111

(M)

10/10/61

W. H. H. H.

VA

10/10/61

11111

USA

10/10/61

10/10/61

10/10/61

10/10/61

(I)

10/10/61

10/10/61

10/10/61

10/10/61

10/10/61

10/10/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11140

11131

| | | | | | | | | | | | | | |
|---|---|---|---|---|--|--|---|--|---|---|-----------------|----------------|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE California b. COUNTY | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Lutherville | | c. LENGTH OF STAY IN 1b
1 yr. 4 mos. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mill Valley | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
College Manor | | | | d. STREET ADDRESS
260 Cleveland Avenue | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) Florence Hite Lineberger | | | | 4. DATE OF DEATH
Oct. 18 19 61 | | | | | | | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 13, 1882 | 9. AGE (In years last birthday) 79 yrs. <table border="1" style="display: inline-table; width: 100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table> | IF UNDER 1 YEAR | IF UNDER 24 HRS. | Months | Days | Hours | Min. | | | |
| IF UNDER 1 YEAR | IF UNDER 24 HRS. | | | | | | | | | | | | |
| Months | Days | | | | | | | | | | | | |
| Hours | Min. | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Architect & Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Lancaster, Ohio | | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. | | | 13. FATHER'S NAME
Levi Hite | | | | | | | | | | |
| 14. MOTHER'S MAIDEN NAME
Elizabeth Courtright | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | | | | | | | | | |
| 16. SOCIAL SECURITY NO.
#571-32-2618 | | | 17. INFORMANT
Address Self <i>Speller R.N. College Manor</i> | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<table style="width: 100%;"> <tr> <td style="width: 30%;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a)
 420.1 DUE TO
 Myocardial infarction </td> <td style="width: 70%;"> INTERVAL BETWEEN ONSET AND DEATH
 2 days </td> </tr> <tr> <td> Conditions, if any, which gave rise to immediate cause (b)
 Generalized arterio sclerosis </td> <td> yo </td> </tr> <tr> <td> (c) DUE TO
 cause last. </td> <td></td> </tr> </table> | | | | | | PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
420.1 DUE TO
Myocardial infarction | INTERVAL BETWEEN ONSET AND DEATH
2 days | Conditions, if any, which gave rise to immediate cause (b)
Generalized arterio sclerosis | yo | (c) DUE TO
cause last. | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
420.1 DUE TO
Myocardial infarction | INTERVAL BETWEEN ONSET AND DEATH
2 days | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (b)
Generalized arterio sclerosis | yo | | | | | | | | | | | | |
| (c) DUE TO
cause last. | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <table style="width: 100%;"> <tr> <td style="width: 30%;"> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) </td> <td style="width: 70%;"> 20c. TIME OF INJURY Month, Day, Year
 Hour a.m. p.m. 19 </td> </tr> <tr> <td> 20d. INJURY OCCURRED
 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> </td> <td> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) </td> </tr> <tr> <td> 20f. (City or town) </td> <td> (County) </td> </tr> <tr> <td> (State) </td> <td></td> </tr> </table> | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | | | | | | | | | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | | | |
| 20f. (City or town) | (County) | | | | | | | | | | | | |
| (State) | | | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>July</i> 1960 to <i>Oct 18</i> 1961 that (I) (we) last saw the deceased alive on <i>Oct 18</i> 1961 and that death occurred at <i>7 P.M.</i> from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
<i>Ernest C Brown</i> | | | | 22b. DATE SIGNED
Oct. 19, 61 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
Ernest C. Brown, Jr. | | | | 22d. ADDRESS
1101 N. Calvert Street
Baltimore 2, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE THEREOF
Oct. 20, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenmount Crematory | | | | | | | | | |
| 23d. LOCATION (City, town or county)
Baltimore | | (State)
Md | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Henry W. Jenkins & Sons, Co.</i> | | | | 25a. REC'D BY REGISTRAR
Oct 20 '61 | | | | | | | | | |
| ADDRESS
4905 York Road | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles S. Thomas</i> | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11160

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

Philadelphia

11142

CERTIFICATE OF DEATH

Reg. Dist. No. 11132

| | | | |
|--|--------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>OLD PHILA RD</u>
<u>COUNTY of Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bradshaw Md.</u> | | c. LENGTH OF STAY IN 1b
<u>50 yrs +</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>Old Philadelphia Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>JENNIE CORNELIA LINGHAM</u> | | 4. DATE OF DEATH Month Day Year
<u>OCT 27 19 61</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>COL</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>FEB 25 1874</u> |
| 9. AGE (In years last birthday) yrs.
<u>87</u> | | IF UNDER 1 YEAR Months Days Hours Min.
<u>87</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>BALTO CO- MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.</u> | |
| 13. FATHER'S NAME
<u>ROBERT OSCAR BERRY</u> | | 14. MOTHER'S MAIDEN NAME
<u>ALBERTA GRAHAM</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) [If yes, give war or dates of service] | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Mrs. Genevia Couplin Bradshaw, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
<u>443X</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Complete Heart Block (since 11-18-60)</u>
DUE TO
(c) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Had adenocarcinoma sigmoid colon removed at Johns Hopkins</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>11 months</u>
<u>unknown</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Heart 1958</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 8</u> , 19 <u>58</u> , to <u>Oct 27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>October 19</u> , 19 <u>61</u> , and that death occurred at <u>7:45</u> A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
<u>Isabel H. McClinton M.D. Bel Air Rd. Kingsville Md. Oct 28/61</u> | | | |
| ACTUAL SIGNATURE <u>Isabel H. McClinton</u> | | PHYSICIAN'S NAME (Type) <u>Isabel H. McClinton Bel Air P. Kingsville Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10-31-61</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Asbury Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Abingdon, Harford Co., Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Frances A. Hensley</u> | | ADDRESS <u>578 W. Biddle St.</u> | |
| 24a. REC'D BY REGISTRAR
DATE <u>Oct 31 '61</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kenna</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11143

11133

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>
c. LENGTH OF STAY IN 1b <u>20 yrs 4 mos 15 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>SPRING GROVE STATE HOSP</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLARKSVILLE</u>
d. STREET ADDRESS <u>RT 32 13X-2</u>
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>LYDIA B LINTHICUM</u> | | 4. DATE OF DEATH
Month <u>OCT</u> Day <u>15</u> Year <u>1961</u> | | 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Nov 7. 1896</u>
9. AGE (In years last birthday) <u>64</u> yrs. | | IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> | | IF UNDER 24 HRS.
Hours <u>0</u> Min. <u>0</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>HOWARD COUNTY MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 13. FATHER'S NAME <u>CHARLES G. LINTHICUM</u>
14. MOTHER'S MAIDEN NAME <u>LYDIA BROSENNE</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>
16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT <u>CHARLES G. LINTHICUM</u>
Address <u>Clarksville Md</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>NEOPLASIA OF THE GASTRIC TRACT</u>
(b) <u>CARCINOMA OF THE PANCREAS</u>
(c) <u>METASTASIS TO THE LIVER</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year <u>19</u>
Hour a.m. <u>4-30</u> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>CLARKSVILLE</u> (County) <u>MD.</u> (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> , 19 <u>61</u> , to <u>10-15</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>10-15-1961</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Ricardo Ibanez</u> M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>RICARDO IBANEZ</u> | | 22d. ADDRESS <u>Spring Grove State Hospital</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>10-17-61</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>LINTHICUM CHAPEL CLARKSVILLE, MD.</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>J.C. Riggleman</u> | | ADDRESS <u>Ellicott City, MD</u> | | 25a. REC'D BY REGISTRAR <u>Oct 18 61</u> | | | |
| 25b. REGISTRAR'S SIGNATURE | | DATE | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11144

Item 22 Film G299 11/7/61 iwk

11134

| | | | | | | | |
|--|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Catonsville | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Glen Burnie, Maryland | | | |
| c. LENGTH OF STAY IN lb
4yr7mth4dys | | | | d. STREET ADDRESS
1604 Heathwood Road | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
Jeremiah Clifton Lynch | | | | 4. DATE OF DEATH
Month October Day 15 Year 19 61 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Oct. 20, 1874 | | 9. AGE (In years last birthday)
86 yrs. | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
boilermaker | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | | 11. BIRTHPLACE (County & State, or foreign country)
U. S. A. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
James Lynch | | | | 14. MOTHER'S MAIDEN NAME
unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
unknown | | 16. SOCIAL SECURITY NO.
214-05-2978 | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic cardiovascular disease
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
420.1 | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (this hospital) attended the deceased from March 11, 1957 to Oct. 15, 1961 , that (I) (we) last saw the deceased alive on Oct. 15, 1961 , and that death occurred at 2 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Stella Wachslar M.D. | | | | 22b. DATE SIGNED
10-17-61 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Stella Wachslar, M. D. | | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Catonsville 28, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
10/20/61 | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY
Anatomy Board-Univ. of Md. | | 23d. LOCATION (City, town or county) (State) | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
ADDRESS | | | | 25a. REC'D BY REGISTRAR
DATE OCT 18 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Kenna | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11135

| | | | |
|---|-------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY 11145 Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN 1b 44 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY 3 V01-4
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 2107 Dobler Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CHARLES E. MADERA | | 4. DATE OF DEATH October 19 1961 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 26, 1922 |
| 9. AGE (In years last birthday) 39 yrs. | | 10. IF UNDER 1 YEAR Months 3 Days 0 | 11. IF UNDER 24 HRS. Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE WORK | | 10b. KIND OF BUSINESS OR INDUSTRY Freight Business | |
| 11. BIRTHPLACE (County & State, or foreign country) Taylor Co West Virginia | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME Joseph J. Madera | | 14. MOTHER'S MAIDEN NAME Lucille Tidghe | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-11 | | 16. SOCIAL SECURITY NO. 236-14-9596 | |
| 17. INFORMANT Clin Rec VAH Baltimore Md Ft Howard Division | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
420.0 DUE TO ARTERIOSCLEROTIC HEART DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) UNKNOWN
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Diabetes Mellitus. Chronic Brain Syndrome
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Sept. 5 1961
Hour a.m. 5:25 p.m. 19
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that X (this hospital) attended the deceased from Sept. 5 1961 to Oct. 19 1961 , that X (we) last saw the deceased alive on Oct. 19 1961 , and that death occurred at 5:25 P.M. from the causes and on the date stated above.
22a. SIGNATURE Thomas F. Crahan M.D.
22b. DATE SIGNED 10-20-61
22c. PHYSICIAN'S NAME (Type) THOMAS F. CRAHAN, M.D.
22d. ADDRESS VAH Baltimore Md - Ft Howard Division
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE THEREOF 10-20-61
23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery
23d. LOCATION (City, town or county) (State) Clarksburg West Virginia
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight Inc
25a. REC'D BY REGISTRAR OCT 27 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

Shipped to Davis-Haymond Funeral Home, Pike St., Clarksburg W.Va.

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1. *Journal of the American Medical Association*, 1997; 277: 1033-1037.

11146

CERTIFICATE OF DEATH

11136

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk (22) | | | | c. LENGTH OF STAY IN lb
35 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
238 Baltimore Avenue | | | | e. STREET ADDRESS
238 Baltimore Avenue | | | |
| f. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First ERNEST Middle E Last MAFFEI | | | | 4. DATE OF DEATH
Month October Day 30th Year 1961 | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 4, 1888 | |
| 9. AGE (In years lost birthday) yrs.
73 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | | 11. BIRTHPLACE (State or foreign country)
Naples, Italy | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Antonio Maffei | | | | 14. MOTHER'S MAIDEN NAME
Marion Simon | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO.
216-09-2913 | | 17. INFORMANT
Daisy R. Maffei Address same as #2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 153.2 Carcinoma of the descending colon with metastases to the liver
DUE TO (b) to lungs
DUE TO (c) Arterio-sclerotic heart disease
INTERVAL BETWEEN ONSET AND DEATH
3 mos.
3-4 years. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 10-7 19 58 , to Oct 30 19 61 , that I last saw the deceased alive on Oct 30 19 61 , and that death occurred at 6:00A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 7001 Morningson Road DATE SIGNED 10/31/61 | | | | | | | |
| ACTUAL SIGNATURE Eugene F. Nevy M.D. | | | | M.D. 7001 Morningson Road 10/31/61 | | | |
| PHYSICIAN'S NAME (Type) Eugene F. Nevy, M.D. | | | | Baltimore 22, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/2/61 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Walter Brooks Bradley, Inc., Dundalk 22, Md. | | | | 24a. REC'D BY REGISTRAR
DATE NOV 1 1961 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hunt | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11130

CERTIFICATE OF DEATH

11130

HAWAIIAN STATE DEPARTMENT OF HEALTH-BUREAU IS

M

| | | | |
|-----------------------|--|-----------------------|--|
| PLACE OF BIRTH | | MARRIAGE | |
| HAWAII | | MARRIED | |
| DATE OF BIRTH | | DATE OF DEATH | |
| JAN 1 1900 | | JAN 1 1900 | |
| AGE | | AGE | |
| 30 | | 30 | |
| SEX | | SEX | |
| MALE | | MALE | |
| RACE | | RACE | |
| CAUCASIAN | | CAUCASIAN | |
| EDUCATION | | EDUCATION | |
| HIGH SCHOOL | | HIGH SCHOOL | |
| OCCUPATION | | OCCUPATION | |
| FARMER | | FARMER | |
| DATE OF DEATH | | DATE OF DEATH | |
| JAN 1 1900 | | JAN 1 1900 | |
| PLACE OF DEATH | | PLACE OF DEATH | |
| HAWAII | | HAWAII | |
| CAUSE OF DEATH | | CAUSE OF DEATH | |
| HEART DISEASE | | HEART DISEASE | |
| MANNER OF DEATH | | MANNER OF DEATH | |
| NATURAL | | NATURAL | |
| SIGNATURE OF DECEASED | | SIGNATURE OF DECEASED | |
| [Signature] | | [Signature] | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| JAN 1 1900 | | JAN 1 1900 | |
| PLACE OF SIGNATURE | | PLACE OF SIGNATURE | |
| HAWAII | | HAWAII | |
| NAME OF WITNESS | | NAME OF WITNESS | |
| JOHN DOE | | JOHN DOE | |
| DATE OF SIGNATURE | | DATE OF SIGNATURE | |
| JAN 1 1900 | | JAN 1 1900 | |
| PLACE OF SIGNATURE | | PLACE OF SIGNATURE | |
| HAWAII | | HAWAII | |

TO SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND****11147****CERTIFICATE OF DEATH****11137**

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
e. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills
c. LENGTH OF STAY IN lb 7 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 2165 Hollins Street
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Michael Joseph MATZDORF
First Middle Last
5. SEX Male
6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 4. DATE OF DEATH 10 6 19 61
Month Day Year
7/23/53
B. DATE OF BIRTH
yrs. Months Days Hours Min.
8 yrs. 7/23/53 | |
| 13. FATHER'S NAME Henry H. Matzdorf
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war and dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Rosewood Records, Owings Mills, Md. | | 14. MOTHER'S MAIDEN NAME Elizabeth Marie Touchard
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration Pneumonia
DUE TO Acute bronchitis (malformation of superior maxillary bone with maximum connective tissue obliteration of nasal passage (naso-pharynx))
CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. 500X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Influenza meningitis with complicating quadriplegia and eye symptomatic epilepsy.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. 19 | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20e. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/23 , 19 54 to 10/6 , 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10/6 , 19 61 , and that death occurred at 1:00 a.m. the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Harry G. Butler
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22d. ADDRESS Rosewood St. Tr. School, Owings Mills, Md.
22b. DATE SIGNED 10/6/61 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 10-9-61
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.
23d. LOCATION (City, town or county) (State) Frederick Ave. Baltimore, Md | | 24. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kenny, Inc 1600 Hollins Balto. Md
25a. REC'D BY REGISTRAR OCT 9 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

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1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 26

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11148

CERTIFICATE OF DEATH

11138

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
6520 Woodbridge Circle | | d. STREET ADDRESS
6520 Woodbridge Circle | |
| 3. NAME OF DECEASED
(Type or print) Florence J. McDonald | | 4. DATE OF DEATH
Month Oct. Day 7 Year 61 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 8, 1885 |
| 9. AGE (In years last birthday)
76 yrs. | | IF UNDER 1 YEAR
Months 2 Days 4 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
May Co. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, M d. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Richard Parry | | 14. MOTHER'S MAIDEN NAME
Catherine Burns | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Thomas J. McCartney, 6520 Woodbridge Circle | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple Metastases squamous cell carcinoma of the floor of mouth
DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(e), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | INTERVAL BETWEEN ONSET AND DEATH
2 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 28, 1959 to Oct 7, 1961 , that (I) (we) last saw the deceased alive on Oct 6, 1961 , and that death occurred at 3:30 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
George A. Knipp | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type)
George A. Knipp M.D. | | 22b. DATE SIGNED | |
| 22d. ADDRESS
4116 Edmondson Ave | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct. 10/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City, town or county) (State)
Baltimore 29, Md | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Fitzke F.D. | | 25a. REC'D BY REGISTRAR
DATE OCT 10 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

11138

11138

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Stationville
6225 Washington Circle
St. Louis, Mo.
June 8, 1965
Dear Sir:
Enclosed please find
one check for \$100.00
payable to the order of
the undersigned.
Very truly yours,
John J. Kennedy

John J. Kennedy
6225 Washington Circle
St. Louis, Mo.
June 8, 1965
Enclosed please find
one check for \$100.00
payable to the order of
the undersigned.
Very truly yours,
John J. Kennedy

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11139

11149

| | | | | | |
|---|--|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> c. LENGTH OF STAY in 1b
<u>1mo. 16 da.</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Spring Grove State Hospital</u> | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
e. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>615 CHESTNUT AVE</u>
d. STREET ADDRESS
<u>BALTIMORE</u> | | |
| 3. NAME OF DECEASED
(Type or print) <u>CATHERINE A. McKENZIE</u> | | | 4. DATE OF DEATH
Month <u>10</u> Day <u>30</u> Year <u>1961</u> | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
<u>10-15-82</u> | 9. AGE (In years last birthday) <u>78</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Stenographer</u> | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Massachusetts</u> | | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | | 13. FATHER'S NAME
<u>William McKenzie</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>Kate Healy</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>Unknown</u> | | |
| 16. SOCIAL SECURITY NO.
<u>212-03-8208</u> | | | 17. INFORMANT
<u>Records: Spring Grove State Hospital</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
DUE TO (b) <u>Arteriosclerotic cardiovalvular disease</u>
DUE TO (c) <u>Generalized arteriosclerosis</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>days</u>
<u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9-14-1961</u> to <u>10-30-1961</u> that (I) (we) last saw the deceased alive on <u>10-30-1961</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>Maurice J. Van Besien</u> M.D. | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
<u>10-30-61</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>MAURICE J. VAN BESIE</u> | | | 22d. ADDRESS
<u>Spring Grove State Hospital</u>
<u>Catonsville, Maryland</u> | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>11-3-61</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Patrick's Church Cem.</u> | |
| 23d. LOCATION (City, town or county) <u>Havre de Grace, Md</u> | | (State) | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
<u>Wm. Cook, Inc., 1217 St. Paul Street</u> | | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 3 '61</u> | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kram</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

1118

21113

(M)

(1)

W.C.K., Inc., 1217 St. Louis Street-More 2
St. Patrick's Church Cem. N. Ave. in Grace, Ill.
11-7-21

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11150

11140

| | | | | | | | |
|--|----------------------------------|---|--|--|--------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville | | c. LENGTH OF STAY IN 1b
6yr5mth21dys | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park, Md. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | d. STREET ADDRESS
432 Ethan Allen Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
William Warren McQueeney | | | | 4. DATE OF DEATH
OCT. 14 1961 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 31, 1903 | 9. AGE (In years last birthday)
57 yrs. | IF UNDER 1 YEAR
Months Days | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
painter | | 10b. KIND OF BUSINESS OR INDUSTRY
construction | | 11. BIRTHPLACE (County & State, or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
William McQueeney | | | | 14. MOTHER'S MAIDEN NAME
Mary Carroll | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
unknown | | 16. SOCIAL SECURITY NO.
579-10-2581 | | 17. INFORMANT
Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
145.0 DUE TO Generalized malignancy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma of Tonsillar Pillar
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour e.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 17, 1955 to 10/14 , 19 61 , that (I) (we) last saw the deceased alive on 10/14 , 19 61 , and that death occurred at 7:15 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Ricardo Ibanez M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 10/15/61 | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Ricardo Ibanez | | | | 22d. ADDRESS
SPRING GROVE STATE HOSPITAL CATONSVILLE 28, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/18/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION (City, town or county) (State)
Fort Myer Va | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Frank Gevers Sons Co | | | | ADDRESS
3605-14 St NW | | 25a. REC'D BY REGISTRAR
OCT 17 '61 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11151

11141

Items 3 & 13 Film G297 10/23/61 mh

| | | | |
|---|---------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland
c. LENGTH OF STAY IN 1b 2 1/2 mo. | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE Maryland
b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater
d. STREET ADDRESS Marlboro Rd. P.O. Box 301
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First JOSEPH Middle Medell Last MEINDENH | | 4. DATE OF DEATH
Month 10 Day 15 Year 19 61 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12. 1. 1913 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Brooklyn, N.Y. |
| 13. FATHER'S NAME JOSEPH MEINDENH | | 14. MOTHER'S MAIDEN NAME ANNA GABRIS | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 717-05-4821 | |
| 17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lymphatic Leucemia
204.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lung abscess | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 8. 2. 1961 to 10. 15. 1961 , that (I) (we) last saw the deceased alive on 10. 15. 1961 , and that death occurred at 6:05 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Wm. Newcomer | | 22b. DATE 10.15.1961 | |
| 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D. Superintendent | | 22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-18-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Mem. Annapolis Md. | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor | | 25a. REC'D BY REGISTRAR Oct 17 '61 | |
| ADDRESS San Annapolis Md. | | 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

2211

12/14/2007

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

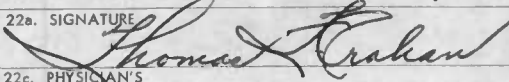
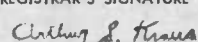
CERTIFICATE OF DEATH

11152

11142

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE
Maryland | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | | c. LENGTH OF STAY IN 1b
18 Days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
JOSEPH H. MEIFARTH | | | | 4. DATE OF DEATH
Month Day Year
October 10 19 61 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
February 12, 1888 | |
| 9. AGE (In years last birthday)
73 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Gardening | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
Henry F. Meifarth | | | | 14. MOTHER'S MAIDEN NAME
Wilhelmina Hofer | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO. (If yes give weor data of service)
WW I 217-22-7597 | | 17. INFORMANT Address
Clinical Records, VAH, Baltimore, 18, Maryland Fort Howard Division | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE
(b) XXXX PULMONARY EMPHYSEMA
(c) XXXX CARCINOMA OF PROSTATE WITH METASTASIS
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 MONTHS

UNKNOWN

1 YEAR | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
Transrectal biopsy-Adenocarcinoma- Operation 9/27/61 | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that XX (this hospital) attended the deceased from September 22, 1961 , to October 10, 1961 , that we (we) last saw the deceased alive on October 10, 1961 , and that death occurred at 4:20 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
 | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
10/10/61 | |
| 22c. PHYSICIAN'S NAME (Type)
THOMAS F. CRAHAN, M.D. | | | | 22d. ADDRESS
VAH, BALTO. 18, MARYLAND, FT. HOWARD DIVISION | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-13-1961 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Jerome Cvach, 900 N. Chester St., Baltimore, Md. | | | | 25a. REC'D BY REGISTRAR
OCT 13 '61 | | 25b. REGISTRAR'S SIGNATURE
 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

11182

11182



RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
WASHINGTON, D. C.
JAN 10 1964
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows, mostly mirrored and difficult to decipher]

THOMAS P. GILBERT, JR.
[Illegible text]
[Illegible text]
[Illegible text]
[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATIS (4)
15M 9/59

1
11153
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11143

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sparks | | | | c. LENGTH OF STAY IN 1b
Life | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
York Road Sparks Maryland | | | | d. STREET ADDRESS
York Road Sparks Md. | | | |
| 3. NAME OF DECEASED (Type or print) Walter Dickinson Merryman
First Middle Last | | | | 4. DATE OF DEATH
Month Day Year
10-16-19 61 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8-20-1878 | |
| 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painting Contractor | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Self employed | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Thomas H. Merryman | | | | 14. MOTHER'S MAIDEN NAME
Martha Garber | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)
No | | | | 16. SOCIAL SECURITY NO.
215-24-0917 | | 17. INFORMANT
W. Leroy Merryman | |
| | | | | Address Timonium Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arterio-sclerotic Cardio-vascular disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/15 to 10/16 , 19 61 , that (I) (we) lost saw the deceased alive on 10/15 19 61 , and that death occurred at 8 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
A. M. France | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
10/15/61 | |
| 22c. PHYSICIAN'S NAME (Type)
A. M. FRANCE | | | | 22d. ADDRESS
PARKTON, MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
10-19-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Foster's | |
| 23d. LOCATION (City, town, or county) (State)
Hereford, Monkton, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Brooks Funeral Service, Towson 4, Md. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE OCT 20 '61 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles S. Thomas | | | |

11143

11153

Bellevue

Bellevue

Bellevue

Sparks

Life

Sparks

York Road Sparks, Md. 10-15-61

Walter Dickinson Sparks

83

2-10-1978

White

Age

Training Contractor Self Employed Maryland U.S.A.

Martha Gardner

Thomas H. Gardner

215-24-0917 V. Leroy Hartman 2945 York Rd. Md.

----- No

hereford, London, No.

Loover's

10-19-61

Burial

Stoke Funeral Service, Towson, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11154

CERTIFICATE OF DEATH

11144

Item 23b, File 6202 10/20/61-11

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY M <u>Baltimore</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>
c. LENGTH OF STAY IN 1b <u>51 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
d. STREET ADDRESS <u>140 W. Clement St - 30</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>GEORGE</u> First <u>MILLER</u> Middle <u>--</u> Last
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>January 2, 1888</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>13</u> Year <u>1961</u> | | | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sand Blaster</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Yard</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>William Miller</u>
14. MOTHER'S MAIDEN NAME <u>Lizzie Fox</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW 1</u>
16. SOCIAL SECURITY NO. <u>219-38-7328</u>
17. INFORMANT <u>Clinical Records, VAH, 3900 Loch Raven Blvd. Balto 18, Md-FORT HOWARD DIVISION</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>465X</u> <u>PULMONARY INFARCTION</u>
(b) <u>BRONCHOPNEUMONIA</u>
(c) <u>PULMONARY HYPERTENSION</u>
PULMONARY INFILTRATION OF UNKNOWN ETIOLOGY
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
Years
Years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Osteoarthritis. Emphysema of lungs. Stricture of esophagus</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>August 23, 1961</u> to <u>Oct. 13, 1961</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Oct. 13, 1961</u> , and that death occurred at <u>P.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Arthur T. Faulk</u> M.D.
22c. PHYSICIAN'S NAME (Type) <u>ARTHUR T. FAULK, M.D.</u> | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>
22d. ADDRESS <u>VAH Baltimore, Md-FORT HOWARD DIVISION</u>
22b. DATE SIGNED <u>10/14/61</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Oct. 17, 1961</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> | | 23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard A. Evans Funeral Home</u> ADDRESS <u>1100 S. Charles St. Baltimore, Maryland</u> | | | | 25a. REC'D BY REGISTRAR <u>OCT 17 '61</u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

ALBERT

M

22-1-55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11155

CERTIFICATE OF DEATH

11145

| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>
c. LENGTH OF STAY IN 1b <u>28 dyas</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE HOSPITAL</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>—</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
d. STREET ADDRESS <u>3719 Edmondson Avenue</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Joseph P. Milligan</u> | | | 4. DATE OF DEATH
Month Day Year
<u>October 2 1961</u> | | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>March 19, 1904</u> | | 9. AGE (In years last birthday)
<u>57 yrs.</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | | 13. FATHER'S NAME
<u>Charles Milligan</u> | | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Anna Crouse</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
<u>unknown</u> | | | | |
| 16. SOCIAL SECURITY NO.
<u>unknown</u> | | | 17. INFORMANT
Address
<u>Records: SPRING GROVE STATE HOSPITAL</u> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of the esophagus</u>
DUE TO (b) <u>—</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 4, 1961</u> to <u>Oct. 2, 1961</u> , that (I) (we) last saw the deceased alive on <u>Oct. 2, 1961</u> , and that death occurred at <u>11:20 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Stella Wachslar</u> M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>10-2-61</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Stella Wachslar, M. D.</u> | | 22d. ADDRESS
<u>SPRING GROVE STATE HOSPITAL</u>
<u>Catonsville 28, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>Oct 4 1961</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>New Cathedral</u> | 23d. LOCATION (City, town or county): (State)
<u>old Frederick Road</u> | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Krause Funeral Home</u> | | ADDRESS
<u>1216 Schaub St</u> | | 25a. REC'D BY REGISTRAR
<u>OCT 6 '61</u> | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Krause</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

11155

11155

M

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Known Tunnel have 1250 feet
Group Oct 1901 New material will find 1000 feet

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11156

CERTIFICATE OF DEATH

Reg. Dist. No.

11146

| | | | |
|--|-----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> | | c. LENGTH OF STAY IN 1b <u>50 YRS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>303 Sollers PT. Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Ella</u> First <u>Camilla</u> Middle <u>NEAL</u> Last | | 4. DATE OF DEATH <u>OCTOBER</u> Month <u>16</u> Day <u>1961</u> Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APRIL 12, 1873</u> |
| 9. AGE (In years last birthday) <u>88</u> yrs. | | 10. IF UNDER 1 YEAR <u>5</u> Months <u>15</u> Days <u>—</u> Hours <u>—</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Private family Cambridge, Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>George Ross</u> | | 14. MOTHER'S MAIDEN NAME <u>Louise Washington</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Louise Hoode 303 Sollers PT. Rd.</u> | |
| 17. INFORMANT <u>Louise Hoode</u> | | Address <u>303 Sollers PT. Rd.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>BRONCHITIS-THROMBOSIS</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO-SCLEROSIS</u>
DUE TO (c) <u>Senility</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u>
<u>15 yrs</u>
<u>?</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>April</u> , 19 <u>45</u> , to <u>OCT 16</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>October 16</u> , 19 <u>61</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>William C. Wade</u> | | ADDRESS (Street, city or town, state) <u>140 Oak Avenue</u> DATE SIGNED <u>10-16-61</u> | |
| PHYSICIAN'S NAME (Type) <u>William C. Wade</u> | | <u>DUNDALK 22, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10-20-61</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u> | 22d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>802 Madison Avenue</u> | | 24a. REC'D BY REGISTRAR <u>OCT 19 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u> | |

DATE

WILLIAM G. WADSWORTH

303 SOLLERS ST. BOSTON

5/10

FEMALE COL.

DECEASED

MOORE ROSS

W

GENERAL PHYSICIAN
 ARTERIO-SCLEROSIS
 SENILITY

WADSWORTH 303 SOLLERS ST. BOSTON

12 MINS
 10 PM
 5

October 10, 1911
 William G. Wadsworth
 William G. Wadsworth

April 10, 1911
 140 Oak Avenue
 Wadsworth St. BOSTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11157
11147
11157
11147

| | | | | | | | | | | | | | | | |
|---|--|------------------------------------|--|---|--|--|--|---|--|--------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard
c. LENGTH OF STAY IN b
3 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE
Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
c. STREET ADDRESS
1011 W. North Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
FRANK J. NOEL | | | | 4. DATE OF DEATH
Month OCTOBER Day 7 Year 1961 | | | | | | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9/30/98 | | 9. AGE (In years last birthday)
63 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | | | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Frank Noel | | | | 14. MOTHER'S MAIDEN NAME
Lavinia Lewis | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes WW I | | | | 16. SOCIAL SECURITY NO.
218-14-7174 | | | | 17. INFORMANT
Clin. Rec. VAH, Balto. Md. Ft. Howard Division | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) LAENNEC'S CIRRHOSIS
581.1 XXXX
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) BRONCHO PNEUMONIA
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) EMPHYSEMA. ARTERIOSCLEROSIS.
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN
4 DAYS | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Baltimore | | (County)
Baltimore | | (State)
Md. | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 4 19 61 to Oct. 7 19 61 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 7 19 61 , and that death occurred at 2:15AM from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
Charles E. Rowan | | | | 22b. DATE SIGNED
10/7/61 | | | | 22c. PHYSICIAN'S NAME (Type)
CHARLES E. ROWAN, M.D. | | | | 22d. ADDRESS
VAH, BALTO. MD. FT. HOWARD DIVISION | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
Oct. 11, 1961 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | | | | 23d. LOCATION (City, town or county)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles R. Law | | | | ADDRESS
802 Madison Avenue
Baltimore, Maryland | | | | 25a. REC'D BY REGISTRAR
OCT 10 '61 | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hume | | | |

223

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11158

11148

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fort Howard
c. LENGTH OF STAY IN 1b
35 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Howard ✓
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Elkridge 27
13X-2
d. STREET ADDRESS
2116 Church Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First JOHN Middle ---- Last PAIMER | | | 4. DATE OF DEATH
Month October Day 11 Year 1961 | | | | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
November 4, 1894 | 9. AGE (In years last birthday) 66 yrs.
IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Trackman | | 10b. KIND OF BUSINESS OR INDUSTRY
Railroad | | 11. BIRTHPLACE (County & State, or foreign country)
Middlerille, Georgia | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | 13. FATHER'S NAME
Iather Palmer | | | | |
| 14. MOTHER'S MAIDEN NAME
Mary Lewis | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes WW I
16. SOCIAL SECURITY NO.
WW I | | | | |
| 17. INFORMANT
Clinical Records VAH, Baltimore 18, Maryland
Fort Howard Division | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
(b) ARTERIOSCLEROTIC HEART DISEASE
(c) DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)
Anemia. Hypertensive Cardiovascular Disease. Rt. Inguinal Hernia. | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 6, 1961 to October 11, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 11, 1961 , and that death occurred at 2:15 p.m. , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE

THOMAS F. CRAHAN, M.D. | | | 22b. DATE SIGNED
10/12/61 | | | | |
| 22c. PHYSICIAN'S NAME (Type)
THOMAS F. CRAHAN, M.D. | | | 22d. ADDRESS
VAH, BALTO. 18, MD., FORT HOWARD DIVISION | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-16-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Arlington S. Phillips, 1808 N. Monroe St. Balto. 17 | | | 25a. REC'D BY REGISTRAR
10/16/61 | | | | |
| 25b. REGISTRAR'S SIGNATURE
 | | | 25c. ADDRESS | | | | |

Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

11198

11198

(M)

Police No. 11198
Date of Birth: 10/10/1910
Place of Birth: New York, N.Y.
Occupation: Police Officer

Height: 5' 10"
Weight: 170 lbs.
Hair: Brown
Eyes: Blue
Blood Type: O+

Married: Yes
Date of Marriage: 10/10/1935
Spouse's Name: Mary Jane Smith
Address: 123 Main St., New York, N.Y.
Phone: 1-234-5678

Education: High School Graduate
Military Service: U.S. Army, 1942-1945
Rank: Sergeant
Discharge: Honorable

Signature: [Signature]
Date: 10/10/1960
Officer: J. Edgar Hoover
Division: Identification Division
Remarks: [Blank]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11159

Item 3 Film G308

5/13/62 iwk

11149

| | | | | | | | |
|--|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Catonsville 11yr7mth9days
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SPRING GROVE STATE HOSPITAL | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
College Park, Maryland
d. STREET ADDRESS
4805 Calvert Road 16712
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Julian Middle I. Last Palmore | | 4. DATE OF DEATH
Month Oct Day 8, Year 19 61 | | | | | |
| 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 8. DATE OF BIRTH
Jan. 14, 1882 | | 9. AGE (In years last birthday) 79 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
chemist | | 10b. KIND OF BUSINESS OR INDUSTRY
Government food industry | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | |
| 13. FATHER'S NAME
unknown | | | 14. MOTHER'S MAIDEN NAME
unknown | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
unknown | | 17. INFORMANT
Address
Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cardiac FAILURE
DUE TO (b) ARTERIOSCLEROSIS
DUE TO (c) CARDIO-VASCULAR DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m.
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (this hospital) attended the deceased from Dec. 28 , 19 49 , to Oct. 8 , 19 61 , that (I) (we) last saw the deceased alive on Oct 8 , 19 61 , and that death occurred at 11 A.M. , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Gerald E. Weinstein M.D.
22c. PHYSICIAN'S NAME (Type)
GERALD E. WEINSTEIN | | | 22b. DATE SIGNED
10/8/61
22d. ADDRESS
SPRING GROVE STATE HOSPITAL
Catonsville 28, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Transportation Oct 11, 1961 | | 23b. DATE THEREOF
Cartersville | | 23c. NAME OF CEMETERY OR CREMATORY
Virginia | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Goschke Jerome De Hone | | 25a. REC'D BY REGISTRAR
DATE OCT 11 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Thoms | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11159

11159

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Transportation Oct 11, 1961 Carterville

Oct 11, 61

Oct 11, 61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | |
| 11160 | | | | | 11150 | | | | | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | | | | | | | |
| a. COUNTY
Baltimore | | | | | a. STATE
Maryland | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard | | | | | b. COUNTY
Maryland | | | | | | | | | |
| c. LENGTH OF STAY in 1b
61 Days | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
7115 Chambers Road, Baltimore 14 | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | | | | d. STREET ADDRESS
7115 Chambers Road | | | | | | | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
ANTON --- PATEK | | | | | 4. DATE OF DEATH
Month Day Year
October 11 19 61 | | | | | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 5, 1907 54 yrs. | | 9. AGE (In years last birthday)
IF UNDER 1 YEAR
Months Days Hours Min. | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Messenger | | 10b. KIND OF BUSINESS OR INDUSTRY
City Fire Department Baltimore, Maryland | | 11. BIRTHPLACE (County & State, or foreign country)
U. S. A. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | | | | | | |
| 13. FATHER'S NAME
Rudolph Patek | | | | | 14. MOTHER'S MAIDEN NAME
Antonette Tomasek | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
Yes WW II | | | | | 16. SOCIAL SECURITY NO.
218-01-6302 | | | | | 17. INFORMANT
Clinical Records, VAH, Baltimore 18, Maryland
FORT HOWARD DIVISION | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMATOSIS, UNIVERSALIS | | | | | | | | | | UNKNOWN | | | | |
| DUE TO BRONCHOGENIC CARCINOMA, RIGHT LUNG | | | | | | | | | | UNKNOWN | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | | |
| 21. I certify that (X) (this hospital) attended the deceased from August 11, 1961 , to October 11, 1961 , that (X) (we) last saw the deceased alive on October 11, 1961 , and that death occurred at 8 P.M. from the causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
Robert J. Ruck M.D. | | | | | 22b. DATE
10/12/61 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
VAH, BALTIMORE, MARYLAND, FT. HOWARD DIVISION | | | | | 22d. ADDRESS
VAH, BALTIMORE, MARYLAND, FT. HOWARD DIVISION | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/16/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. | | 23d. LOCATION (City, town or county)
Baltimore 28, Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Leonard J. Ruck & Sons, 5305 Harford Rd., Balto. 14 Md. | | | | | 25a. REC'D BY REGISTRAR
OCT 13 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hume | | | | | | | |

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Old Line Department Baltimore, Maryland

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11161

CERTIFICATE OF DEATH

11151

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN 1b 12 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 3230 Ravenwood Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First HENRY Middle -- Last REINHARD
4. DATE OF DEATH
Month October Day 16 Year 1961 | | 5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH July 6, 1893 9. AGE (in years last birthday) 68 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assemblyman
10b. KIND OF BUSINESS OR INDUSTRY Automobile Mfg Co Baltimore, Maryland
11. BIRTHPLACE (County & State, or foreign country) USA
12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME John G. Reinhard
14. MOTHER'S MAIDEN NAME Louise Wagner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) WW-1
16. SOCIAL SECURITY NO. WW-1
17. INFORMANT Clin Rec VAH Baltimore Md Ft Howard Division
Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO
(c) UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 17 DAYS | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19
20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 4, 1961 to October 16, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 16, 1961 , and that death occurred at 5:45 P.M. from the causes and on the date stated above. | |
| 22a. SIGNATURE Daniel R. Zoll M.D.
22c. PHYSICIAN'S NAME (Type) Daniel R. Zoll M.D.
22d. ADDRESS VAH Baltimore Md - Ft Howard Division | | 22b. DATE SIGNED 10-16-61
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 10/20/61
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery
23d. LOCATION (City, town or county) (State) Baltimore Maryland | | 25a. REC'D BY REGISTRAR OCT 19 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Ulrich Funeral Home
ADDRESS 4210 Belair Road Baltimore Maryland | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11162

CERTIFICATE OF DEATH

11152

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore County</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>
c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3704 CASSEN RD.</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Balto. Co.</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>
d. STREET ADDRESS <u>13704 CASSEN RD.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>FREDERICK S. RIDGAWAY</u>
First Middle Last
5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>JAN. 15, 1880</u>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | 4. DATE OF DEATH <u>OCT. 3, 1961</u>
Month Day Year | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER, HARRY S. SCOTT PRINTING Co.</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | | 13. FATHER'S NAME <u>SAMUEL S. RIDGAWAY</u>
14. MOTHER'S MAIDEN NAME <u>ANNIE H. SNEAD</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>
16. SOCIAL SECURITY NO. <u>212-035309A</u>
17. INFORMANT <u>MISS ETHEL G. RIDGAWAY</u>
Address <u>3704 CASSEN RD. RANDALLSTOWN MD.</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute heart failure</u>
<u>450.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u>
(c) <u>and old age</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>—</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>—</u> | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>✓</u> p.m. <u>19</u>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>✓</u>
20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1945</u> to <u>Oct. 3, 1961</u> ; that (I) (we) last saw the deceased alive on <u>Oct. 3, 1961</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>H. W. Scheye</u> M.D.
22c. PHYSICIAN'S NAME (Type) <u>H. W. SCHEYE MD</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <u>3921 EDMONDSON AVE</u>
22b. DATE SIGNED <u>Oct. 4, 61</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>
23b. DATE THEREOF <u>10/6/61</u>
23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK CEMT</u>
23d. LOCATION (City, town or county) (State) <u>BALTO. MD.</u> | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE FUN. DIR.</u> ADDRESS <u>4101 EDMONDSON AVE</u>
25a. REC'D BY REGISTRAR <u>OCT 6 '61</u> DATE
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u> | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
11163
CERTIFICATE OF DEATH
11153

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|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
c. LENGTH OF STAY IN 1b X
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md.
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 6108 Sunny Lane #7
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Edna Middle W. Last Riggs | | | | 4. DATE OF DEATH
Month Oct. Day 19, Year 1961 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Oct. 22, 1896 | |
| 9. AGE (In years lost birthday) 64 yrs. | | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Macgregor, Canada | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | |
| 13. FATHER'S NAME John Watson | | | | 14. MOTHER'S MAIDEN NAME Margaret Lamb | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 217-34-9077 | | 17. INFORMANT Helen J. Burn, 6108 Sunny Lane #7 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
331X IMMEDIATE CAUSE (a) arteriosclerotic cerebral vascular disease
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (c) _____
DUE TO (d) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH 3 yrs | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from July 1963 to Oct. 19 , 19 61 , that (I) (we) last saw the deceased alive on Oct 17 , 19 61 , and that death occurred at 4:45 PM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
John A. Nesbitt Jr. | | | | 22b. ADDRESS
John A. Nesbitt, Jr., M.D. 4 S. Rolling Rd. | | 22c. PHYSICIAN'S NAME (Type) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 10/20/61 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory | | 23d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Howard H. Hubbard | | | | 25a. REC'D BY REGISTRAR
OCT 23 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Hume | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 11164 | | | | | | 11154 | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) | | | | | |
| a. COUNTY | | | Baltimore | | | a. STATE | | | Md | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | Arbutus | | | b. COUNTY | | | Baltimore | | |
| c. LENGTH OF STAY IN 1b | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | Arbutus | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | | d. STREET ADDRESS | | | | | |
| 217 Oaklee Village | | | | | | 217 Oaklee Village | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | | 4. DATE OF DEATH | | | | | |
| JOHN O. ROBINSON SR. | | | | | | Oct. 27 1961 | | | | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED | | 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| M | | W | | <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | | 10/1/94 | | 67 yrs. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country) | | | |
| Baltimore Transit ret. | | | | | | | | Md | | | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| Ephraim Robinson | | | | | | Young | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | |
| Yes | | | | WWF 213103075 | | | | John O. Robinson Jr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Coronary Occlusion | | | | | | | | | | | |
| 420.0 DUE TO | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (b) Atherosclerotic Heart Disease | | | | | | | | | | | |
| (a), stating the underlying cause last. DUE TO | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| Sugis. | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY | | | | 20d. INJURY OCCURRED | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| Month, Day, Year | | | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20f. (City or town) (County) (State) | | | |
| Hour a.m. p.m. | | | | 19 | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 1960, to Oct 27, 1961, that (I) (we) last saw the deceased alive on Oct 16, 1961, and that death occurred at 1 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED | | |
| Emmett P. Davis | | | | | | M.D. | | | 10/30/61 | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS | | | | | |
| Emmett P. Davis | | | | | | 1515 Washington Blvd. Baltimore 30, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE THEREOF | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | |
| Burial | | | | 10/31/61 | | | | Baltimore National | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | |
| MacDuff & Son | | | | 28 | | | | NOV 1 '61 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | | | Arthur L. Hume | | | |

11154

11154

(M)

(1)

1015 11/15/54

1015 11/15/54

28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | |
|---|--|----------------------------------|--|---|--|--|--|---|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 11165 Item 7 Film G302 11155 | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
<i>Baltimore</i> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission)
a. STATE <i>Md.</i>
b. COUNTY <i>Baltimore</i>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>X Parkville</i> | | | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Parkville</i> | | | | c. LENGTH OF STAY IN 1b | | | | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>2809 Garnet Rd.</i> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
<i>Carroll Richard Roeder</i> | | | | 4. DATE OF DEATH
Month <i>10</i> Day <i>5</i> Year <i>61</i> | | | | | | | | | | | |
| 5. SEX
<i>male</i> | | 6. COLOR OR RACE
<i>white</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>5-23-1894</i> | | 9. AGE (In years last birthday)
<i>67</i> yrs. | | IF UNDER 1 YEAR
Months <i></i> Days <i></i> | | IF UNDER 24 HRS.
Hours <i></i> Min. <i></i> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Retired</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Electrician</i> | | | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Maryland</i> | | | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | |
| 13. FATHER'S NAME
<i>Joseph H. Roeder</i> | | | | 14. MOTHER'S MAIDEN NAME
<i>Rosa Kathman</i> | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
<i>213107462</i> | | | | 16. SOCIAL SECURITY NO.
<i>213107462</i> | | | | 17. INFORMANT
<i>Marian B. Roeder</i> | | | | Address
<i>same</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
<i>420.1</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>Infected bursa, right elbow (healed)</i> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>17 days</i> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY
Hour a.m. <i>19</i>
p.m. <i>19</i> | | Month, Day, Year | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Sept 18, 1961</i> to <i>Oct 5, 1961</i> , that (I) (we) last saw the deceased alive on <i>Sept 5, 1961</i> , and that death occurred at <i>5:45</i> A.M. from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
<i>G. M. Bacon</i> | | | | M.D.
<i>A. M. BACON</i> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<i>10/6/61</i> | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<i>A. M. BACON</i> | | | | 22d. ADDRESS
<i>2810 Taylor Ave.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>burial</i> | | | | 23b. DATE THEREOF
<i>10-9-61</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Moreland Mem. Park</i> | | 23d. LOCATION (City, town or county)
<i>Baltimore,</i> | | (State)
<i>Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>L onard J. Ruck</i> | | | | ADDRESS
<i>5305 Harford Rd.</i> | | | | 25a. REC'D BY REGISTRAR
DATE <i>OCT 9 '61</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Thomas</i> | | | | | |

VR A15 (4)
15M 9/60

1951

1951

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11166

11156

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTIMORE</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>TOWSON CONVALESCENT HOME</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>
d. STREET ADDRESS <u>701 WASHINGTON AVENUE</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>WILLIAM ARTHUR ROGERS</u>
First Middle Last
4. DATE OF DEATH <u>OCTOBER 28 1961</u>
Month Day Year | | 5. SEX <u>MALE</u>
6. COLOR OR RACE <u>WHITE</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>OCT. 23, 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER - RET.</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>WILLIAM HENRY ROGERS</u>
14. MOTHER'S MAIDEN NAME <u>?</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>
16. SOCIAL SECURITY NO. <u>—</u>
17. INFORMANT <u>FAMILY RECORDS</u> Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Decomposition</u>
442X DUE TO (b) <u>Arteriosclerotic Cardio-Renal</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Vascular Disease</u>
10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS PRECEDING OR CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>—</u>
INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS.</u>
WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u>
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from <u>April 1949</u> to <u>October, 1961</u> , that (I) (we) last saw the deceased alive on <u>10/27 1961</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. | |
| 22a. SIGNATURE <u>Charles F. O'Donnell</u> M.D.
22c. PHYSICIAN'S NAME (Type) <u>Charles F. O'Donnell</u>
22d. ADDRESS <u>7501 York Rd - Towson, Md.</u> | | 22b. DATE SIGNED <u>10/30/61</u>
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>
23b. DATE THEREOF <u>OCT. 31, 1961</u>
23c. NAME OF CEMETERY OR CREMATORY <u>PROSPECT HILL CEM.</u>
23d. LOCATION (City, town or county) (State) <u>TOWSON, MD.</u> | | 24. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Jones</u> ADDRESS <u>Towson, Md.</u>
25a. REC'D BY REGISTRAR <u>NOV 2 '61</u> DATE
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> | |

11120

11165



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11167

CERTIFICATE OF DEATH

11157

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard
c. LENGTH OF STAY IN lb 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 22
d. STREET ADDRESS 212 Parkwood Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle T. Last RYAN | | | | 4. DATE OF DEATH
Month October Day 9 Year 19 61 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH December 27, 1899 61 | |
| 9. AGE (In years last birthday) 61 yrs. | | | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | 13. FATHER'S NAME Samuel Ryan | | | |
| 14. MOTHER'S MAIDEN NAME MN: Unknown | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I | | | |
| 16. SOCIAL SECURITY NO. 212-10-2184 | | | | 17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BILATERAL TUBERCULOSIS, PULMONARY, WITH CAVITATION
XXXX RIGHT LUNG AND TUBERCULOUS PNEUMONIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACTIVE
DUE TO (c) UNKNOWN | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 6, 1961 to October 9, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 9, 1961 , and that death occurred at 6:40 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Sebastian Russo M.D. | | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 10/9/61 | |
| 22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D. | | | | 22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-11-61 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith | | 23d. LOCATION (City, town or county) (State) Baltimore County, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14 | | | | 25a. REC'D BY REGISTRAR OCT 10 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Hume | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Md.

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|----------------------------------|---|--|--|--|--|--|---|---|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 11168 CERTIFICATE OF DEATH 11158 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY Baltimore | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reisterstown | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Kemp Road | | | | | d. STREET ADDRESS
Kemp Road | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) Henry A. Schaefer | | | | | 4. DATE OF DEATH
Month October Day 12 Year 1961 | | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 16, 1876 | | 9. AGE (In years last birthday)
84 yrs. | IF UNDER 1 YEAR
Months 84 Days 0 | IF UNDER 24 HRS.
Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Henry C. Schaefer | | | | | 14. MOTHER'S MAIDEN NAME
Annie Walters | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
217-36-4089 | | 17. INFORMANT
Address John Edward Schaefer, Kemp Road, Reisterstown, Md. | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardio-Vascular Disease
(e), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 days
years | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour e.m. 19 p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-20-49 , 19 6-20-49 , to 10-12 , 1961, that (I) (we) last saw the deceased alive on 10-12-1961 , and that death occurred 11:30 P.M. on the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
Martin E. Strobel M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
10-13-61 | | |
| 22c. PHYSICIAN'S NAME (Type) Martin E. Strobel, M.D. | | | | | 22d. ADDRESS
48 Main St. Reisterstown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
Oct. 15, 1961 | | 23c. NAME OF CEMETERY OR CREMATORY
All-Saints Cemetery | | 23d. LOCATION (City, town or county) (State)
Reisterstown, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
J.F. Eline & Sons, Reisterstown, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE OCT 17 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | | |

9811

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Sincerely,

SI-01 PA-OS-d

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10-11-01

• 31, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 26

... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11169

CERTIFICATE OF DEATH

11159

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore R. Schmoll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>—</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville-Paradise & Altamont</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Paradise Nursing Home</u> | | d. STREET ADDRESS <u>767 Grantley Street</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Blanche R. Schmoll</u> | | 4. DATE OF DEATH <u>Oct. 26 19 61</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 28, 1884</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>William R. Roberts</u> | | 14. MOTHER'S MAIDEN NAME <u>? Evans</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Mrs. Katherine Newman-1230 Stevens Avenue</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
<u>4 20</u> IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>
DUE TO (b) <u>generalized arteriosclerosis</u>
DUE TO (c) <u>—</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2-11-53</u> , 19 <u>—</u> , to <u>10-26-61</u> , 19 <u>—</u> , that (I) (we) last saw the deceased alive on <u>10-24-61</u> , 19 <u>—</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>For S. Gimble</u> | | 22b. DATE SIGNED <u>10/24/61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>EARLY S. GIMBLE</u> | | 22d. ADDRESS <u>4605 Edmonson Ave</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>10-28-61</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Jackson & Sons</u> | | 25a. REC'D BY REGISTRAR <u>OCT 27 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u> | |

1113

1113

(M)

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11170 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11160

1
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, within 72 hours after death.

| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>
c. LENGTH OF STAY IN 1b <u>3 yrs</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>35 Kinship Rd.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Balto</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Dundalk</u>
d. STREET ADDRESS <u>1 35 Kinship Rd</u> | | | | | | | | | | | | | | | | | |
|--|------|--|------|---|--|--|--|--|--|-----------------|--|------------------|--|--------|------|-------|------|--|--|--|--|
| 3. NAME OF DECEASED (Type or print)
<u>Joseph G. Schultz</u> | | | | 4. DATE OF DEATH
Month <u>Oct.</u> Day <u>12</u> Year <u>1961</u> | | | | | | | | | | | | | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 30 - 07</u> | | 9. AGE (In years last birthday) <u>54</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. | | | | |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Smelter</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Armoco Co.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Balto. Md</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | | | | | | | |
| 13. FATHER'S NAME
<u>John Schultz</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Anna Zakor</u> | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u>212-07-8555</u> | | 17. INFORMANT
Address <u>Joseph L Schultz 1804 Darrich Dr. (14)</u> | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u>
Conditions, if any, which gave rise to immediate cause (b) <u> </u>
(a), stating the underlying cause last. DUE TO (c) <u> </u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>None</u> | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year <u>19</u>
Hour a.m. <u> </u> p.m. <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) | | | | | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>M.B. Davis</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>M.B. Davis MD</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <u>10/14/61</u> | | | | | | | | | | | | | | | | | |
| Address (Street, city, town, or county) <u> </u> | | | | | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>OCT 16 - 61</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Holy Redeemer</u> | | 22d. LOCATION (City, town, or country) (State)
<u>Bolton Rd. Balto. G. Md.</u> | | | | | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR
<u>Reginald Bros.</u> | | | | 24a. REC'D BY REGISTRAR | | | | | | | | | | | | | | | | | |
| ADDRESS <u>1800 E. Lombard St.</u> | | | | 24b. REGISTRAR'S SIGNATURE
<u>Charles S. Harris</u> | | | | | | | | | | | | | | | | | |

OCT 16 1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11171

CERTIFICATE OF DEATH

11161

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <i>Baltimore</i> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>7912 Beverly Road</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>
d. STREET ADDRESS <i>7912 Beverly Road</i>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <i>Mildred</i> Middle <i>G.</i> Last <i>Scotney</i> | | 4. DATE OF DEATH
Month <i>October</i> Day <i>25</i> Year <i>1961</i> | |
| 5. SEX
<i>female</i> | 6. COLOR OR RACE
<i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>8-6-1913</i> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <i>48</i> yrs.
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i> |
| 13. FATHER'S NAME
<i>Charles Schultz</i> | | 14. MOTHER'S MAIDEN NAME
<i>Lula M. Smith</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<i>214201744</i> | | 16. SOCIAL SECURITY NO.
<i>Herbert M. Scotney, Jr.</i> | |
| 17. INFORMANT
<i>same</i> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>171X Menia</i>
DUE TO (b) <i>Uteral Obstruction</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <i>Carcinoma of the Cervix (IC. 4)</i>
INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>
<i>3 mos</i>
<i>JAN 61</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>Vesicovaginal fistula post irradiation</i> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. <i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (the hospital) attended the deceased from <i>Jan 1961</i> to <i>Oct 25, 1961</i> , that (I) (we) last saw the deceased alive on <i>10/17/1961</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>John Horwell Hebb</i> M.D. | | 22b. DATE SIGNED
<i>10/25/61</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>JOHN HOREWELL HEBB</i> | | 22d. ADDRESS
<i>701 CATHERAC BLVD. 12 MD</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>burial</i> | 23b. DATE THEREOF
<i>10-28-61</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Parkwood Cemetery</i> | 23d. LOCATION (City, town or county) (State)
<i>Baltimore, Md.</i> |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Leonard J. Ruck</i> | | 25a. REC'D BY REGISTRAR
<i>5305 Harford Rd.</i> | |
| 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Hines</i> | | DATE
<i>OCT 27 '61</i> | |

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CERTIFICATE OF DEATH

Reg. Dist. No. 11162

11172

| | | | | | | | |
|--|------------------------------|--|---------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b
<u>22 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> <u>3V014</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Home in the Pines Nursing & Convalescent Home</u> | | | | d. STREET ADDRESS
<u>1442 Haubert ST</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>MATHIAS</u> Middle <u>SEIF</u> Last <u>SEIF</u> | | | | 4. DATE OF DEATH
Month <u>10</u> - Day <u>25</u> Year <u>1961</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>10-22-1891</u> | 9. AGE (In years last birthday)
<u>80</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Barber</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | | 11. BIRTHPLACE (State or foreign country)
<u>Hungary</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | |
| 13. FATHER'S NAME
<u>Mathias Seif</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>220-30-0620</u> | | 17. INFORMANT
Address <u>Mrs. Anna Seif 1442 Haubert ST.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u>
DUE TO (b) <u>Atherosclerosis of C. v. D.</u>
DUE TO (c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Fracture - Intertrochanteric Rt. - 9/24/61. Mtd.</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Open fracture of T. 5. D.</u> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. <u> </u> p. m. <u> </u> 19 <u>61</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9/22</u> , 19 <u>61</u> , to <u>10/25</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>10/18</u> , 19 <u>61</u> , and that death occurred at <u>5:00</u> P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Baltimore, Md.</u> DATE SIGNED <u> </u> | | | | | | | |
| ACTUAL SIGNATURE <u>E. S. ELISON</u> M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>E. S. ELISON</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>10-30-61</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>New Cathedral Cemetery Baltimore, Md.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles L. Stevens</u>
<u>Funeral Home, Inc.</u> | | | | ADDRESS
<u>1501 E. Fort Ave.</u> | | 24a. REC'D BY REGISTRAR
<u>NOV 1 '61</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Quibing & Hume</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11173

CERTIFICATE OF DEATH

11163

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills
c. LENGTH OF STAY IN lb 16 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)
e. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills
d. STREET ADDRESS 11220 Reisterstown Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Richard A. Smith | | 4. DATE OF DEATH
Last Smith Month October Day 3 Year 1961 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 16, 1904 |
| 9. AGE (In years last birthday) 57 yrs.
IF UNDER 1 YEAR Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker
10b. KIND OF BUSINESS OR INDUSTRY Bakery
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME
Richard Smith | | 14. MOTHER'S MAIDEN NAME
Mary Ann Durham | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
Yes WW II | | 16. SOCIAL SECURITY NO. 212-07-8792
17. INFORMANT Mrs. Richard A. Smith Address 11220 Reis. Rd. Owings Mills, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac Decompensation
DUE TO (b) Secondary to Pulmonary Fibrosis
(c) Pulmonary Tuberculosis
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
6 mos.
2 yrs.
2 yr. 9mo. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Renal Insufficiency | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)
none | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
none | |
| 20c. TIME OF INJURY
Hour e.m. none
p.m. | 20d. INJURY OCCURED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> none | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1-5-50 , 19 , to 10-3-61 , 19 , that (I) (we) last saw the deceased alive on 10-2-61 , 19 , and that death occurred at 2A AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
D.D. Caples | | 22b. DATE SIGNED
10-4-61 | |
| 22c. PHYSICIAN'S NAME (Type) D.D. Caples, M. D. | | 22d. ADDRESS
6 Hanover Rd., Reisterstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF
Oct. 6, 1961 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. | 23d. LOCATION (City, town or county) (State)
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Henry James Eckhardt | | 25a. REC'D BY REGISTRAR
OCT 5 '61 | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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10-5-01

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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
SM 9/60

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | | | |
|---|--|-------------------------------|--|---|--|---|--|--|--|---|--|--|--|--|--|
| Items 10-21 Film 300
11-15-61
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11174 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12392
Item 7 Film G300
11/16/61 | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Dundalk
d. STREET ADDRESS 2511 Yorkway | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First CHARLES Middle - Last STEPHENS | | | | 4. DATE OF DEATH October 31 1961
Month October Day 31 Year 1961 | | | | | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 21, 1938 | | 9. AGE (In years last birthday) 23 yrs. | | IF UNDER 1 YEAR
Months 23 Days 0 | | IF UNDER 24 HRS.
Hours 0 Min. 0 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Lin Mill | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Beck Steel | | | | 11. BIRTHPLACE (State or foreign country)
New York | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 13. FATHER'S NAME
Charles W. Stephens | | | | | | 14. MOTHER'S MAIDEN NAME
Amelia Goldbaum | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. (If yes give year or dates of service) | | | | 17. INFORMANT Address
Ellen Stephens 2511 Yorkway | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Undetermined - Drowning or electrocution
936.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
(c) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Found dead in bathtub full of water with radio submerged in tub | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 7:30 PM 10-31-61 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/>
at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | | | 20f. (City or town) (County) (State)
Dundalk Balto. Md. | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Howard G. Shaub | | | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> 10-31-61 DATE SIGNED | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| EXAMINER'S NAME (Type)
Howard G. Shaub, M. D. | | | | Address (Street, city, town, or county) | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
Nov 3/61 | | 22c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cem | | | | 22d. LOCATION (City, town, or country) (State)
Baltimore County | | | | | |
| 23. FUNERAL DIRECTOR ADDRESS
Ullrich Funeral Home 2112 Dundalk | | | | | | 24a. REC'D BY REGISTRAR
NOV 14 '61 | | | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Hines | | | | | |

(M)

(1)

Approved by Mr. [illegible]

For the [illegible] of the [illegible] [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11175

11164

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Arbutus 27 | | c. LENGTH OF STAY IN 1b
Arbutus 27 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
1212 Poplar Avenue | | d. STREET ADDRESS
1212 Poplar Avenue | |
| 3. NAME OF DECEASED (Type or print)
First Alice Middle Stoetzer Last Stoetzer | | 4. DATE OF DEATH
Month October Day 18 Year 1961 | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 24, 1883 |
| 9. AGE (In years last birthday)
77 yrs. | | IF UNDER 1 YEAR
Months 77 Days 77 | IF UNDER 24 HRS.
Hours 77 Min. 77 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Baltimore, Md | |
| 11. BIRTHPLACE (County & State, or foreign country)
U.S.A. | | 12. CITIZEN OF WHAT COUNTRY
U.S.A. | |
| 13. FATHER'S NAME
William Whitworth | | 14. MOTHER'S MAIDEN NAME
unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
219-22-6852 | |
| 17. INFORMANT
Richard F. Stoetzer, 1212 Poplar Ave | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO H+ASCD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) unknown
(c) unknown | | INTERVAL BETWEEN ONSET AND DEATH
10 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-6-56 to 10-24-61 , 19 61 , that (I) (we) last saw the deceased alive on 10-23-61 , 19 61 , and that death occurred at 8 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Nathan Racusin | | 22b. DATE SIGNED
10-20-60 | |
| 22c. PHYSICIAN'S NAME (Type)
Nathan Racusin, M.D. | | 22d. ADDRESS
206 South Gilmore Street, ZONE 23 | |
| 23a. BURIAL, CREMATION, REBURYAL (Specify)
BURIAL | | 23b. DATE THEREOF
10-23-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook, Inc, 1217 St. Paul Street, ZONE 2 | | 25a. REC'D BY REGISTRAR
OCT 24 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | |

MEDICAL CERTIFICATION

(M)

Baltimore

October 27

1512 Poplar Avenue

Miss

October 18

1512 Poplar Avenue

October 24, 1883

x

white

female

Honorable

at 1114 Whitworth

Baltimore, Md

unknown

(I)

21-2-883

Richard J. Dwyer, 1512 Poplar Ave

21-2-883

Richard J. Dwyer

21-2-883

Baltimore

Nathan Escobar, N.Y.

206 South Gilmore Street, Baltimore

10-23-01

Baltimore Cemetery

Baltimore

W. Scott, Inc., 1217 St. Paul Street, Baltimore

11175

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11165

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1005 St. Charles Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Robert Middle Edward Last Storm | | 4. DATE OF DEATH
Month Oct. Day 3 Year 1961 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 8, 1900 |
| 9. AGE (In years last birthday)
61 yrs. | | 10. IF UNDER 1 YEAR
Months 6 Days 1 Hours 1 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
supervisor | | 10b. KIND OF BUSINESS OR INDUSTRY
General Elect. Co. | |
| 11. BIRTHPLACE (State or foreign country)
Md. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Frank Storm | | 14. MOTHER'S MAIDEN NAME
Catherine Shriner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
215-09-8793 | |
| 17. INFORMANT
Ruth M. Storm | | Address
1005 St. Charles Ave. #29 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchogenic Carcinoma
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH
6 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 1, 1961 , to October 3, 1961 , that (I) (we) lost the deceased alive on October 2, 1961 , and that death occurred at 3A M., from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Morris Steinberg | | 22b. DATE SIGNED
10/4/61 | |
| 22c. PHYSICIAN'S NAME (Type)
Morris Steinberg, M. D. | | 22d. ADDRESS
3913 Hollins Ferry Rd. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/6/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Howard H. Hubbard | | 25a. REC'D BY REGISTRAR
Oct 5 '61 | |
| ADDRESS
4107 Wilkens Avenue | | 25b. REGISTRAR'S SIGNATURE
Charles S. Evans | |

(M)

(I)



1175

CERTIFICATE OF DEATH

1175

1005 E. Charles Avenue

Aug. 3, 1900

Frank Brown

1125 W. 1st St. N. W. Station 1 of 10. Charles Ave.

North Station, N. D. XNA 2011 Hold as Yet: 10.

10/5/01

1005 E. Charles Avenue

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11177 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11166

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|---|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk (22) | | c. LENGTH OF STAY IN b
24 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk (22) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
129 Ventnor Terrace | | | | d. STREET ADDRESS
129 Ventnor Terrace | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
BERNARD VIRGIL STRADTNER | | | | 4. DATE OF DEATH
Month Day Year
October 10th, 19 61 | | | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 7th, 1902 | 9. AGE (In years last birthday)
59 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Welder | | 10b. KIND OF BUSINESS OR INDUSTRY
Steel | | 11. BIRTHPLACE (State or foreign country)
Indiana | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John C. Stradtner | | | | 14. MOTHER'S MAIDEN NAME
Alma Cobble | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
213-09-1819 | | 17. INFORMANT
Florence O. Stradtner same as #2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)
420.1 DUE TO
Coronary Occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
Heart | | | | | |
| 20c. TIME OF INJURY
Hour e.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
Dundalk | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Melvin B. Davis, M.D. | | DATE SIGNED
10/11/61 | | | | | |
| EXAMINER'S NAME (Type)
Melvin B. Davis, M.D. | | Address (Street, city, town, or county) | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
10/13/61 | 22c. NAME OF CEMETERY OR CREMATORY
Meadowridge Memorial | | 22d. LOCATION (City, town, or country) (State)
Dorsey, Maryland | | | |
| 23. FUNERAL DIRECTOR
Walter Brooks Bradley, Inc., Dundalk 22, Md. | | | | 24a. REC'D BY REGISTRAR
OCT 13 '61 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Finner | |

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122 VENT OF LARVAE

122 VENT OF LARVAE

October 1961

10.10.1961

White

USA

Indiana

1961

older

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19-02-1019 Florence G. Thompson, born at 2
1961

10/11/61

10/11/61

After Thomas Stanley, Inc., Newark, N.J., 1961, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 1961

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11178

11167

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
e. COUNTY Baltimore MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 116 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie
d. STREET ADDRESS 204 Poplar Avenue | | | |
| 3. NAME OF DECEASED (Type or print) CARLYN M STUART
First Middle Last
(CAROLYN) | | | | 4. DATE OF DEATH October 1 1961
Month Day Year | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper | | 10b. KIND OF BUSINESS OR INDUSTRY | | 9. AGE (In years last birthday) 76 yrs.
IF UNDER 1 YEAR: Months Days Hours Min. | | | |
| 11. BIRTHPLACE (County & State, or foreign country) Baltimore Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Jacob Wittich | | | | 14. MOTHER'S MAIDEN NAME Marie Dukehart | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-1 | | | | 16. SOCIAL SECURITY NO. WW-1 | | | |
| 17. INFORMANT Clin Rec VAH Baltimore Md Ft Howard Division | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CALCIFIC AORTIC STENOSIS
DUE TO (b) RHEUMATIC HEART DISEASE
DUE TO (c) Hypertensive Vascular Disease; Arteriosclerotic Heart Disease; Diverticulosis. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour e.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 7 1961 to Oct 1 1961 that no (we) last saw the deceased alive on Oct 1 1961 , and that death occurred at 3:25 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>C. M. Snyder</i> M.D. | | | | 22b. DATE SIGNED 10-1-61 | | | |
| 22c. PHYSICIAN'S NAME (Type) C. M. SNYDER | | | | 22d. ADDRESS VAH Baltimore Md - Ft Howard Division | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10-4-61 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | | |
| 23d. LOCATION (City, town or county) Baltimore Maryland | | 23e. REC'D BY REGISTRAR DATE OCT 10 '61 | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc. | | | | 25. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 8 Film G297 10/24/61 mh

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Mt. Washington | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Mt. Washington | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
1218 Lake Avenue | | d. STREET ADDRESS
1218 Lake Avenue | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
ANNIE FISHPAW Fishpaw STULLER | | 4. DATE OF DEATH
Month Day Year
October 15, 19 61 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 11, 1878 |
| 9. AGE (In years last birthday)
88 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Fishpaw | | 14. MOTHER'S MAIDEN NAME
Sally King | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No None None | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Family Records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(e), stating the underlying cause last. (c)
DUE TO
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | INTERVAL BETWEEN ONSET AND DEATH
2 months
5 yrs. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 25, 1961 to Oct 15th 1961 , that (I) (we) last saw the deceased alive on Sept 20th 1961 , and that death occurred at 2:30 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
James A. Miller M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
James A. Miller M.D. | | 22d. ADDRESS
1331 Reisterstown Rd
Pikesville - Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
Oct. 18, 1961 | 23c. NAME OF CEMETERY OR CREMATORY
Jessops Methodist Cemetery | 23d. LOCATION (City, town or county) (State)
Cockeysville, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John Burns' Sons, Towson, Maryland | | 25a. REC'D BY REGISTRAR
DATE OCT 19 '61 | |
| 25b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | | | |

M

I

11/11/1911

1218 Lake Avenue

1218 Lake Avenue

Housewife

John Bishop

John Bishop

John Bishop

11/11/1911

x

Own home

John Bishop

1218 Lake Avenue

Housewife

John Bishop

John Bishop

11/11/1911

1218 Lake Avenue

1218 Lake Avenue

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1218 Lake Avenue

John Bishop, 1218 Lake Avenue, Towson, Maryland

11/11/1911

CERTIFICATE OF DEATH

Reg. Dist. No. 11169

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Donnalh | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 731 S. Avondale Rd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Landonia Reed SWANN | | 4. DATE OF DEATH Month Day Year October 25, 1961 | |
| 5. SEX Female | 6. COLOR OR RACE Col. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH MAY 20-1896 |
| 9. AGE (In years last birthday) 65 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WORKED ON FARM | | 10b. KIND OF BUSINESS OR INDUSTRY Tobacco | |
| 11. BIRTHPLACE (State or foreign country) Farmville, Va | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME Sallie Reed | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Sallie Swann | | Address 731 S. Avondale Rd | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 420.0 DUE TO Uremia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO-SCLEROTIC HEART DISEASE DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 2 days 1 hr. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 1954 to October 25, 1961 , that I last saw the deceased alive on October 25, 1961 , and that death occurred at M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE William C. Wade | | ADDRESS (Street, city or town, state) 140 Oak Ave. DATE SIGNED 10/25/61 | |
| PHYSICIAN'S NAME (Type) William C. Wade | | Donnalh 22, Md | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10-29-61 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law | | ADDRESS 802 Madison Ave., Balto., 1, Md | |
| 24a. REC'D BY REGISTRAR OCT 27 '61 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Harris | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11181

11170

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Halethorpe | | | | c. LENGTH OF STAY IN 1b
2 Years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
4506 Poplar Ave | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
LYDIA W TAYLOR First Middle Last | | | | 4. DATE OF DEATH
Month Oct. Day 1 Year 1961 | | | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 12, 1881 | | 9. AGE (In years last birthday)
80 yrs. | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (State or foreign country)
Canada | | 12. CITIZEN OF WHAT COUNTRY?
Canada ✓ | |
| 13. FATHER'S NAME
Isaac Springstead | | | | 14. MOTHER'S MAIDEN NAME
Catherine McIntosh | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
William W. Taylor, 4506 Poplar Ave. Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of rectum
154X DUE TO (impaired)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease
DUE TO Senility (c) 5 yrs | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
14 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 1961 to Oct 1961 , that (I) (we) last saw the deceased alive on Sept 30 1961 , and that death occurred at 6:30 M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
B B Brumbough M.D. | | | | 22b. DATE SIGNED
10/2/61 | | 22c. PHYSICIAN'S NAME (Type)
B B Brumbough | |
| 22d. ADDRESS
5609 main st | | | | 22e. ADDRESS
Edwards 27 md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10/5/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodland Cemetery | | 23d. LOCATION (City, town, or county) (State)
Hamilton, Ontario, Canada | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Howard H. Hubbard, 4107 Wilkens Ave, | | | | 25a. REC'D BY REGISTRAR
Oct 3 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

11170

CERTIFICATE OF DEATH

11181

M

LATIA W. TAYLOR

50

Sept. 1, 1961

X

Canada

Canada

Canadian National

and Southern

W. R. Taylor, 1900 Taylor St.

home

W

HAMILTON, ONTARIO, CANADA

1000 Taylor Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 3 & 9, telephone call - Stewart & Mowen Co. - 10/24/61, cac.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lutherville
c. LENGTH OF STAY IN 1b Abt-5 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) COLLEGE MANOR | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson
d. STREET ADDRESS Dulaney Valley Road.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
ARTHUR EDGAR THAIN | | 4. DATE OF DEATH
Month October Day 19 Year 1961 | |
| 5. SEX Male
6. COLOR OR RACE White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Dec-16-1881
9. AGE (In years last birthday) 79 yrs. IF UNDER 1 YEAR: Months 8 Days 16 IF UNDER 24 HRS. Hours 10 Min. 45 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY Heating Equipment
11. BIRTHPLACE (County & State, or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME John T. Thain
14. MOTHER'S MAIDEN NAME Sarah E. Lewis | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
16. SOCIAL SECURITY NO. 162-10-9999
17. INFORMANT W.E. Thain, (son) Charlotte 9, N.C. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA, RIGHT BASE
DUE TO (b) CEREBRAL-VASCULAR THROMBOSIS
DUE TO (c) GENERALIZED ARTERIOSCLEROSIS
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) MYOPATHY, ETIOLOGY UNDETERMINED | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from JULY 1957 to OCT 19 1961 , that (I) had last saw the deceased alive on OCT 19 1961 , and that death occurred 8:20 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE T. C. Siwinski
22c. PHYSICIAN'S NAME (Type) T. C. Siwinski, M.D. | | 22b. DATE SIGNED 10/20/61
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS 206 W. Penna. Ave., Towson 4, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE THEREOF 10/21/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Woodlawn | | 23d. LOCATION (City, town or county) (State) Woodlawn, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Stewart & Mowen Co., 108-W-North-Av Balto. 1. | | 25a. REC'D BY REGISTRAR OCT 23 61
25b. REGISTRAR'S SIGNATURE Arthur S. Hanks | |

1118

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MAYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|-------------------------------|--|---|--|---|--|---|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 11-6-61 | | | | | | | | | | | | | |
| 11183 | | | | | | | | | | | | | |
| 11172 | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore
c. LENGTH OF STAY IN lb MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1106 Longbrook Road | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
d. STREET ADDRESS 1106 Longbrook Road
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) (BABY) FRANK CARLISLE TISCH, JR. | | | | | | 4. DATE OF DEATH Oct. 30 1961 | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Sept. 26, 1961 | | 9. AGE (In years last birthday) 1 yrs. 4 Months 4 Days | | IF UNDER 1 YEAR 1 IF UNDER 24 HRS. 4 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md. | | | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Frank Carlisle Tisch | | | | | | 14. MOTHER'S MAIDEN NAME Judith Stanley | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | 16. SOCIAL SECURITY NO. (If yes give year or dates of service) | | 17. INFORMANT Frank C. Tisch, 1106 Longbrook Rd. | | | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Suffocation
924.9 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Child was on abdomen and worked its face into plastic bunting which cut off the air | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. - p.m. 19 | | | | | | 20d. INJURY OCCURED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (the hospital) attended the deceased from Sept. 26, 1961 to Oct. 30, 1961 , that (I) (we) saw the deceased alive on Oct. 30, 1961 , and that death occurred at 9:45 AM , from the causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE Laurence C. Tisch | | | | | | 22b. DATE SIGNED 10/31/61 | | 22c. ADDRESS 6805 York Rd. - Baltimore Md | | | | | |
| 22c. PHYSICIAN'S NAME (Type) LAURENCE C. Tisch | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify) Crementation | | | | | | 23b. DATE THEREOF Oct. 31/61 | | 23c. NAME OF CEMETERY OR CREMATORY Greenmount | | 23d. LOCATION (City, town or county) (State) Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson, Inc. | | | | | | ADDRESS 1050 York Rd. 4 | | 25a. REC'D BY REGISTRAR NOV 2 '61 | | 25b. REGISTRAR'S SIGNATURE Arthur S. Thoma | | | |

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11122

11122



Bellevue, Md.

Bellevue, Md.

Bellevue, Md.

Bellevue, Md.

Bellevue, Md.

Bellevue, Md.

Bellevue, Md.

(BANK) 7-11-61

Bellevue, Md.

Bellevue, Md.

Bellevue, Md.

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Bellevue, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) | | | |
|--|--|--|--|--|--|--|--|
| a. COUNTY | | | | a. STATE | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | b. COUNTY | | | |
| c. LENGTH OF STAY IN 1b | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | d. STREET ADDRESS | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | 4. DATE OF DEATH | | | |
| First Middle Last | | | | Month Day Year | | | |
| 5. SEX | | | | 6. COLOR OR RACE | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 8. DATE OF BIRTH | | | |
| 9. AGE (In years last birthday) yrs. | | | | IF UNDER 1 YEAR Months Days | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (County & State, or foreign country) | | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | | |
| 17. INFORMANT Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral metastases, carcinoma of breast</u>
170X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | INTERVAL BETWEEN ONSET AND DEATH
9 yrs. | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1948</u> , 19 <u>48</u> to <u>Oct 7</u> , 19 <u>61</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Oct 7</u> , 19 <u>61</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE M.D. | | | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE THEREOF | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City, town or county) (State) | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | |

VR A15 (4)
15M 9/60

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11185

11174

| | | | | | | | |
|---|----------------------------------|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk (22) | | c. LENGTH OF STAY IN lb
33 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk (22) | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
6903 Holabird Avenue | | | | d. STREET ADDRESS
6903 Holabird Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Katherine M. Uphoff | | | | 4. DATE OF DEATH
Month October Day 18th Year 1961 | | | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 10, 1882 | | 9. AGE (In years last birthday)
79 yrs. | IF UNDER 1 YEAR
Months 0 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA |
| 13. FATHER'S NAME
George Kirschenhofer | | | | 14. MOTHER'S MAIDEN NAME
Mary Reinhardt | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
William Uphoff Address same as #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 434.1 Congestive heart failure
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
DUE TO (c) _____
INTERVAL BETWEEN ONSET AND DEATH 1 week | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 0 a. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
Jack Collins | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type)
Jack Collins | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/21/61 | | 22c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore Co., Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Walter Brooks Bradley, Inc., Dundalk 22, Md. | | | | 24a. REC'D BY REGISTRAR
Oct 20 '61 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

11186

CERTIFICATE OF DEATH

Reg. Dist. No. 11175

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Md. b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Colgate | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Colgate | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
7615 Eastern Blvd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First MARY Middle CAROLINE Last VANDERMAST | | 4. DATE OF DEATH
Month October Day 21 Year 19 61 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 24, 1880 |
| 9. AGE (In years last birthday)
81 yrs. | | 10. IF UNDER 1 YEAR
Months 3 Days 15 Hours 45 Min. | 11. IF UNDER 24 HRS.
Months 3 Days 15 Hours 45 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY
House Work. | |
| 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John M. White | | 14. MOTHER'S MAIDEN NAME
Maria L. Davis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | |
| 17. INFORMANT
Mrs. Marie Connor | | Address
501 Fairview Ave. Balto., Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Heart Disease DUE TO
(c) 15 years | | INTERVAL BETWEEN ONSET AND DEATH
3 weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/20/57 , 19 57 , to 10/21/61 , 19 61 , that I last saw the deceased alive on 10/20/61 , 19 61 , and that death occurred at 8:45 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Ulay Baum | | ADDRESS (Street, city or town, state) 7422 EASTERN AVE Baltimore, Md. | |
| PHYSICIAN'S NAME (Type) MAX BAUM | | DATE SIGNED 10/23/61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10-25-61 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 22d. LOCATION (City, town, or county) (State)
7225 Eastern Blvd. Md. Balto. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles S. Geiler | | ADDRESS
6224 Eastern Ave. MD. | |
| 24a. REC'D BY REGISTRAR
DATE OCT 26 '61 | | 24b. REGISTRAR'S SIGNATURE
Charles S. Geiler | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11175

CHITRA (CO) IN

11180



[Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.]

VS. A15ME
5M 7/59

11176

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Balto.</u> | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Balto</u> <u>29</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Pikesville 8.</u> | | c. LENGTH OF STAY IN 1b
<u>30 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>701 Cliveden Rd.</u> | | d. STREET ADDRESS
<u>4105 Flomerton Rd.</u> | |
| 3. NAME OF DECEASED
(Type or print)
Nicholas | | 4. DATE OF DEATH
Month <u>October</u> Day <u>31</u> Year <u>1961</u> | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 6, 1892 |
| 9. AGE (In years last birthday)
68 yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | |
| 11. IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | 12. CITIZEN OF WHAT COUNTRY?
Yes -U.S.A. | |
| 13. FATHER'S NAME
Christopher Vasich | | 14. MOTHER'S MAIDEN NAME
Draga Lukich | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
 | |
| 17. INFORMANT
Lucille Vasich-701 Cliveden Rd., Pikesville, Md. | | Address
 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
<u>4201</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u>
DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
30 min. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
none | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.
none | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
none | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. none 19
p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>
none | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none | | 20f. (City or town) (County) (State)
none | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>D. D. Caples</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) D. D. Caples, M. D., 6 Hanover Rd., Reisterstown, Md. | | DATE SIGNED 11-3-61 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-4-61 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Moreland Memorial Cemetery | | 22d. LOCATION (City, town, or country) (State)
Baltimore, Md. | |
| 23. FUNERAL DIRECTOR
<u>Ellsworth Armacost</u>
Ellsworth Armacost, 4600 Liberty Heights Ave., Balto., Md. | | 24a. REC'D BY REGISTRAR
DATE NOV 6 '61 | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | |

1
FOR STATE
HEALTH DEPT.

TO JUDICIAL MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 11188 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| Item 7 Film 9299 11/6/61 iwk 11177 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Baltimore | | | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville | | | | c. LENGTH OF STAY in 1b MARYLAND | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 209 Westshire Road | | | | e. STREET ADDRESS 606Biddle Street | | | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First LILLIAN Middle Vessel Last Vessel | | | | 4. DATE OF DEATH
Month October Day 28 Year 19 61 | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Colored | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 15, 02 59 | | 9. AGE (In years last birthday) 59 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months 59 Days 59 Hours 59 Min. 59 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Rodger Brooks | | | | 14. MOTHER'S MAIDEN NAME Lillian Sides | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. 218-30-6100 | | | | 17. INFORMANT Alfred Coleman Address 3107 Philps Lane | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
443 IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease.
DUE TO
Conditions, if any, which gave rise to immediate cause (b) 443
(c) 443
DUE TO
(e), stating the underlying cause last. (c) 443 | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles S. Petty | | | | M.D. Charles S. Petty | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Charles S. Petty, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF Nov. 2, 1961 | | 22c. NAME OF CEMETERY OR CREMATORY West Chapel Cemetery | | 22d. LOCATION (City, town, or country) (State) Westminister, Maryland | | | |
| 23. FUNERAL DIRECTOR Arlington S. Phillips ADDRESS 1808 W. Monroe St. | | | | | | 24a. REC'D BY REGISTRAR NOV 1 '61 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Travis | | | |

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3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11189
11178
CERTIFICATE OF DEATH

| | | | | | |
|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fort Howard
c. LENGTH OF STAY IN 1b
64 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Dorchester
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Cambridge
d. STREET ADDRESS
Arcade Apartments
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
LAIRD H. VINTON | | | 4. DATE OF DEATH
Month
October
Day
10
Year
1961 | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
April 17, 1889 | | 9. AGE (In years last birthday)
72 yrs. | | IF UNDER 1 YEAR
Months
09
Days
13 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
Machine shop | | 11. BIRTHPLACE (County & State, or foreign country)
Cambridge, Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 13. FATHER'S NAME
Edward P. Vinton | | | |
| 14. MOTHER'S MAIDEN NAME
Eldora Bromwell | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | |
| 16. SOCIAL SECURITY NO.
214-07-8370 | | 17. INFORMANT
Clinical Records, VAH, Baltimore 18, Maryland
FORT HOWARD DIVISION | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA, LEFT LUNG, WITH METASTASES
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Bronchoscopy - 8/21/61 - Bronchogenic carcinoma, left lower lobe, bronchus | | | | INTERVAL BETWEEN ONSET AND DEATH
UNKNOWN
UNKNOWN | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20a. TIME OF INJURY
Hour e.m.
p.m.
19 | | 20d. INJURY OCCURRED
While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
Cambridge | | 20g. (County)
Dorchester | | 20h. (State)
Maryland | |
| 21. I certify that (a) (this hospital) attended the deceased from August 7, 1961 to October 10, 1961 that (b) (we) last saw the deceased alive on October 10, 1961 and that death occurred at 3:45 p.m. from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
Thomas F. Crahan | | 22b. DATE SIGNED
10/11/61 | | 22c. PHYSICIAN'S NAME (Type)
THOMAS F. CRAHAN, M.D. | |
| 22d. ADDRESS
VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV. | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | |
| 23b. DATE THEREOF
10/13/61 | | 23c. NAME OF CEMETERY OR CREMATORY
Dorchester Memorial Cemetery | | 23d. LOCATION (City, town or county)
Cambridge, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Howard H. Hubbard | | 25a. REC'D BY REGISTRAR
OCT 16 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11190

CERTIFICATE OF DEATH

11179

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1109 Concordia Drive | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson
d. STREET ADDRESS 1109 Concordia Drive
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LOUISE CATHERINE WAGNER | | 4. DATE OF DEATH Oct. 26, 1961 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 30, 1921 |
| 9. AGE (In years last birthday) 40 | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY 214-14-7168 | |
| 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME William G. Lentzner, Sr. | | 14. MOTHER'S MAIDEN NAME Louise C. Hohn | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 214-14-7168 | |
| 17. INFORMANT Robert G. Wagner-1109 Concordia Dr., Towson | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) metastatic carcinoma
180X DUE TO (b) Hypernephroma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
INTERVAL BETWEEN ONSET AND DEATH 4 mos
1 yr | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 25, 1961 to Oct 26, 1961 , that (I) (we) last saw the deceased alive on Oct 25, 1961 , and that death occurred at 11 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE George T. Gilmore M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) GEORGE T. GILMORE | | 22d. ADDRESS Lutherville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 10/30/61 | 23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Gardens | 23d. LOCATION (City, town or county) (State) Timonium, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc. | | 25a. REC'D BY REGISTRAR Oct 30 '61 | |
| ADDRESS York Rd., Towson, Md. | | 25b. REGISTRAR'S SIGNATURE Arthur L. ... | |

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Salisbury

Salisbury

Salisbury

London

London

1100 Concordia Drive

1100 Concordia Drive

Oct. 1, 1961

WATKIN

CATWATER

to

July 30, 1961

to

USA

Salisbury

Salisbury

London N. York

London N. York

1100 Concordia Drive

to

Salisbury, Maryland

1100 Concordia Drive, Salisbury, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|---|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 11191 | | | | | | | | | |
| 11180 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> <u>MARYLAND</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Towson</u> | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Dulaney Village, Towson</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>14 Tenbury Road</u> | | | | | e. STREET ADDRESS
<u>14 Tenbury Road</u> | | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Timothy</u> Middle <u>Matthew</u> Last <u>Ward</u> | | | | | 4. DATE OF DEATH
Month <u>10</u> Day <u>10</u> Year <u>19 61</u> | | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Oct. 16, 1884</u> | | 9. AGE (In years last birthday)
<u>76</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Maintenance</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | a. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13. FATHER'S NAME
<u>Michael J. Ward</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Not known</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>219104322</u> | | | | | 17. INFORMANT
<u>MRS MARY REARY</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerosis, Cerebral Vascular Disease</u>
(c) <u>Cerebral aneurysm, chronic</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 yr</u>
<u>3 yrs</u> | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>24 Sept</u> <u>1961</u> to <u>10 Oct</u> <u>1961</u> , that (I) <u>()</u> last saw the deceased alive on <u>10 Oct</u> <u>1961</u> , and that death occurred at <u>9A</u> <u>M</u> , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Howard Goodman</u> | | | | | 22b. DATE SIGNED | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Howard Goodman</u> | | | | | 22d. ADDRESS
<u>8604 Hankard Rd Baltimore, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | | | | 23b. DATE THEREOF
<u>10-14-61</u> | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>New Cathedral Cem.</u> | | | | | 23d. LOCATION (City, town or county) (State)
<u>Baltimore, Md.</u> | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Ruck</u> | | | | | 25a. REC'D BY REGISTRAR
<u>Arthur S. Finner</u> | | | | |
| ADDRESS
<u>5305 Harford Rd.</u> | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Finner</u> | | | | |
| DATE
<u>OCT 13 '61</u> | | | | | | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

11181

11192

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville
c. LENGTH OF STAY IN b 7yr6mth27dys
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Maryland
d. STREET ADDRESS 4808 Sheridan Street
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) Herman Elliott Watson | | 4. DATE OF DEATH
Month October Day 17 Year 1961 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 10, 1911 |
| 9. AGE (In years last birthday) 50 yrs. | | IF UNDER 1 YEAR: Months 50 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer | | 10b. KIND OF BUSINESS OR INDUSTRY farm | 11. BIRTHPLACE (County & State, or foreign country) Georgia |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Herman Watson | |
| 14. MOTHER'S MAIDEN NAME Roxie Smith | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown | |
| 16. SOCIAL SECURITY NO. 217-32-2640 | | 17. INFORMANT Records: SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 157X DUE TO INTESTINAL HEMORRHAGE (Melena)
Conditions, if any, which gave rise to immediate cause (b) Cancer of Pancreas
(c) 157X DUE TO Cancer of Pancreas
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 157X | | INTERVAL BETWEEN ONSET AND DEATH 1-2 days | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m. 3:25 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 22, 1961 to Oct. 17, 1961 that (I) (we) last saw the deceased alive on Oct. 17, 1961 , and that death occurred at 3:25 P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Stella Wachsler M.D. | | 22b. DATE SIGNED 10-17-61 | |
| 22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. | | 22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Transportation | 23b. DATE THEREOF Oct 19, 1961 | 23c. NAME OF CEMETERY OR CREMATORY Forsyth | 23d. LOCATION (City, town or county) (State) Georgia |
| 24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville Md | | 25a. REC'D BY REGISTRAR OCT 20 '61 25b. REGISTRAR'S SIGNATURE Charles S. Kraus | |

MEDICAL CERTIFICATION

The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11181

11181

M

1

Cancer of Pancreas
INTESTINAL HEMORRHOIDS (New)

X

TRANSPORTATION CO. 1981
1000 N. 1st St.
MILWAUKEE, WIS. 53233

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11182**

11193

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Middle River #20 | | | | c. LENGTH OF STAY IN 1b
X | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
69 Cool Breeze Trailer Park | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
John H. Welch | | | | 4. DATE OF DEATH
Month 10 Day 18 Year 1961 | | | |
| 5. SEX
M | | 6. COLOR OR RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov. 3, 1903 | |
| 9. AGE (In years last birthday)
57 yrs. | | IF UNDER 1 YEAR
Months 57 Days 18 | | IF UNDER 24 HRS.
Hours 18 Min. 1961 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Boiler Maker | | 10b. KIND OF BUSINESS OR INDUSTRY
Boiler Industry | | 11. BIRTHPLACE (State or foreign country)
Georgia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Unknown | | | | 14. MOTHER'S MAIDEN NAME
Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
176-03-6347 | | 17. INFORMANT
Gladys Welch | | Address
Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart dis.
420.1 DUE TO 1 1/2 weeks in m
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 1/2 weeks in m
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 years
2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Hour 19 o. m. 19 p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE
Jack C. Collins | | | | DATE SIGNED
10-18-61 | | | |
| EXAMINER'S NAME (Type)
Jack C. Collins | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/21/61 | | 22c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James E. Bruzdziński | | | | ADDRESS
1407 Eastern Ave. | | 24a. REC'D BY REGISTRAR
DATE OCT 20 '61 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | |

MEDICAL CERTIFICATION

TO BE COMPLETED BY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11198

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11198

| | | | | | | | | | |
|-----------------------|--|------------------------|--|------------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Death | | Place of Death | |
| John Thomas Walker | | Male | | 45 | | Nov 3, 1907 | | Home | |
| Cause of Death | | Disease | | Injury | | Poison | | Other | |
| Heart Failure | | Myocarditis | | None | | None | | None | |
| Manner of Death | | Occupation | | Education | | Religion | | Marital Status | |
| Natural | | Carpenter | | High School | | Catholic | | Married | |
| Signature of Examiner | | Signature of Physician | | Signature of Coroner | | Signature of Registrar | | Signature of Witness | |
| J. H. Smith | | D. E. Jones | | W. B. Brown | | M. C. Green | | A. F. White | |
| Date of Certificate | | Place of Issue | | Signature of Registrar | | Signature of Coroner | | Signature of Physician | |
| Nov 5, 1907 | | Baltimore | | M. C. Green | | W. B. Brown | | D. E. Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|----------------------------------|--|---|--|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 11194 CERTIFICATE OF DEATH 11183 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard
c. LENGTH OF STAY IN Tb
5 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Veterans Administration Hospital | | | | | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore 23
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
2223 W. Fayette Street
d. STREET ADDRESS
2223 W. Fayette Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print)
HOWARD
First Middle Last
WEST | | | | | | 4. DATE OF DEATH
Month Day Year
October 13 1961 | | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
November 23, 1928
32 yrs. | | 9. AGE (In years last birthday)
32 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Bartender | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Maryland | | | |
| 13. FATHER'S NAME
Herman C. West | | | | 14. MOTHER'S MAIDEN NAME
Hazel Giles | | | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO.
220-20-3999 | | | | 17. INFORMANT
Clinical Records, VAH, Baltimore 18, Maryland
FORT HOWARD DIVISION | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA
491X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CIRRHOSIS OF LIVER
(c) DUE TO | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 Days
UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
(County)
(State) | | | |
| 21. I certify that he (this hospital) attended the deceased from October 8, 1961 to October 13, 1961 , that he (we) last saw the deceased alive on October 13, 1961 , and that death occurred at 3:50 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Sebastian Russo
M.D.
22c. PHYSICIAN'S NAME (Type)
SEBASTIAN RUSSO, M.D. | | | | | | 22b. DATE SIGNED
10/13/61
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
10-17-61 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. | | 23d. LOCATION (City, town or county)
Baltimore 28, Maryland
(State) | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Charles G. Cooper
ADDRESS
510-12 Carrollton Ave. Balto. | | | | | | 25a. REC'D BY REGISTRAR
OCT 20 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Thomas | | | |

Md.

11183

11184

(M)

(1)

RECEIVED
JAN 11 1964
U. S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
MEMORANDUM
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows, mostly mirrored bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11195

11184

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Fort Howard
c. LENGTH OF STAY IN TB
20 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
1003 Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
23
d. STREET ADDRESS
1003 Bennett Place
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
FERNIE ---- WHITE | | 4. DATE OF DEATH
Month Day Year
October 3 19 61 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
October 22, 1889 |
| 9. AGE (in years last birthday)
71 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Crane Operator - Ret. | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Washington N. Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Edward White | | 14. MOTHER'S MAIDEN NAME
Susan - Maiden name unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
218-05-6104 | |
| 17. INFORMANT
Address
Clinical Records, VAH, Baltimore 18, Maryland
Fort Howard Division | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BILATERAL PNEUMONIA
Conditions, if any, which gave rise to immediate cause (b) MYOCARDIAL SCLEROSIS DUE TO
(a), stating the underlying cause last. LUETIC AORTITIS
(c) CHRONIC CYSTITIS | | INTERVAL BETWEEN ONSET AND DEATH
1 DAY +
UNKNOWN
UNKNOWN
UNKNOWN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 13, 1961 to October 3, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 3, 1961 , and that death occurred at 8:30 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Sebastian Russo | | 22b. DATE SIGNED
10/5/61 | |
| 22c. PHYSICIAN'S NAME (Type)
SEBASTIAN RUSSO, M.D. | | 22d. ADDRESS
VAH, BALTIMORE 18, MARYLAND, FT. HOWARD, DIV. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
10-9-61 | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National | 23d. LOCATION (City, town or county) (State)
Baltimore 28, Maryland |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Elroy Wilson | | ADDRESS
Funeral Home 1000 Brantley Ave. Baltimore 17, Md. | |
| 25a. REC'D BY REGISTRAR
DATE
OCT 11 '61 | | 25b. REGISTRAR'S SIGNATURE
Arthur E. Harris | |

VR A15 (4)
15M 9/60

11183

11183

M

1000 hours at 11:00
1000 hours at 11:00
1000 hours at 11:00

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1000 hours at 11:00

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11196

11185

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>BALTO.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ESSEX</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ESSEX</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>908 LUTZ AVE.</u> | | | | d. STREET ADDRESS
<u>1908 LUTZ AVE.</u> | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>HARRY</u> Middle <u>M</u> Last <u>WIENEKE</u> | | | | 4. DATE OF DEATH
Month <u>OCT.</u> Day <u>17</u> Year <u>1961</u> | | | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3-18-85</u> | 9. AGE (In years last birthday)
<u>76</u> yrs. | IF UNDER 1 YEAR
Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. | IF UNDER 24 HRS.
Hours <u>76</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>BALTO. TRANSIT (RETIRED)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO.
<u>215-09-3735</u> | | 17. INFORMANT
<u>Mrs. Ethel Bowers (Same as above)</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIAC DECOMPENSATION</u>
<u>420.0</u> DUE TO <u>ARTERIO-SCLEROTIC</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HEART DISEASE</u>
DUE TO (c) | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 WEEKS</u>
<u>20 YRS</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u>19</u> p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MAY 15</u> 19 <u>58</u> to <u>OCT 17</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>OCT 16</u> 19 <u>61</u> , and that death occurred at <u>1045</u> A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Joseph Miceli</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>10/20/61</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JOSEPH MICELI M.D.</u> | | | | 22d. ADDRESS
<u>108 S. TAYLOR AVE BALTO. 21 MD.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>10-20-61</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>BALTO. CEMETERY</u> | | 23d. LOCATION (City, town, or county) (State)
<u>BALTO. CITY MD.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>John S. Connelly</u> | | | | ADDRESS
<u>418 Eastern Blvd.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>OCT 23 '61</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kraus</u> | | | | | | | |

M

I

MEDICAL CERTIFICATION

11111

11111

(M)

TO: THE CHIEF OF STAFF
FROM: THE CHIEF OF STAFF
SUBJECT: [Illegible]

[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or official communication.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13 & 14 Film G297 10/6/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. **11186**

11197

| | | | |
|---|----------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE Delaware b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Towson | | c. LENGTH OF STAY IN lb
Two Weeks | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
1619 Thetford Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Nannie S. Middle Wilder Last | | 4. DATE OF DEATH
Month October Day 1 Year 1961 | |
| 5. SEX F. | 6. COLOR OR RACE W. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Feb. 2, 1885 |
| 9. AGE (In years lost birthday) 76 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
at home | |
| 11. BIRTHPLACE (State or foreign country)
Boston Mass. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph N. Pearsall | | 14. MOTHER'S MAIDEN NAME
Harreitt Stiles | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
William H. Wilder, 4100 Dudley Ave. Balto. 6 Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
420.1 DUE TO (b) 2 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Oct 1 , 19 61 to Oct 1 , 19 61 , that I last saw the deceased alive on Oct 1 , 19 61 , and that death occurred at 9 a.m. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 8400 Loch Raven Blvd. DATE SIGNED 10/2/61
ACTUAL SIGNATURE Joseph F. Lipira
PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
10/4/61 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Baltimore Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
HENRY SANDER & SONS INC. BALTO. MD. | | 24a. REC'D BY REGISTRAR
DATE OCT 3 '61 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Hanna | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

1272

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11198

11187

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort Howard
c. LENGTH OF STAY IN 1b
4 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Veterans Administration Hospital | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore 13
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
1809 E. Lafayette Avenue
d. STREET ADDRESS
1809 E. Lafayette Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
JOHN
First
WILSON
Middle

Last | | 4. DATE OF DEATH
October 4 1961
Month Day Year | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
December 25, 1892 | |
| 9. AGE (In years last birthday)
68 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 11. BIRTHPLACE (County & State, or foreign country)
Sumter, S. Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Daisy: Mn: Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | 16. SOCIAL SECURITY NO.
WW I 217-20-4791 | |
| 17. INFORMANT
Clinical Records, VAH, Fort Howard Division
Baltimore 18, Maryland | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BILATERAL TUBERCULOUS PNEUMONIA
DUE TO (b) 002X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 30, 1961 to October 4, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 4, 1961 , and that death occurred at P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
Sebastian Russo
22c. PHYSICIAN'S NAME (Type)
SEBASTIAN RUSSO, M.D. | | 22b. DATE SIGNED
10/5/61
22d. ADDRESS
VAH, BALTIMORE 18, MD. FT. HOWARD DIVISION | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
10-9-61 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | 23d. LOCATION (City, town or county) (State)
Baltimore 28, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Elroy O. Wilson
ADDRESS
1000 Brantley Ave. Baltimore 17, Md. | | 25a. REC'D BY REGISTRAR
OCT 11 '61
25b. REGISTRAR'S SIGNATURE
Arthur E. Thomas | |

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1111



Director
Mr. Tolson
Mr. E. A. Tamm
Mr. Clegg
Mr. Glavin
Mr. Ladd
Mr. Nichols
Mr. Rosen
Mr. Tracy
Mr. Carson
Mr. Egan
Mr. Gurnea
Mr. Hendon
Mr. Pennington
Mr. Quinn
Mr. Nease
Miss Gandy

October 11, 1936
Dear Sir:

Enclosed for the Bureau are two copies of a letterhead memorandum from the New York Office, dated October 9, 1936, captioned as above. The New York Office is conducting an investigation of the activities of the American Friends of the British Committee, and has advised that the same may be of interest to the Bureau.

Very truly yours,
Special Agent in Charge

Handwritten signature
N. 13

Enclosed for the Bureau are two copies of a letterhead memorandum from the New York Office, dated October 9, 1936, captioned as above. The New York Office is conducting an investigation of the activities of the American Friends of the British Committee, and has advised that the same may be of interest to the Bureau.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **11188**

11193

| | | | | | | | | |
|--|--|--|--|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore Co. MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Md. b. COUNTY Baltimore | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Dundalk | | | c. LENGTH OF STAY IN 1b
 | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X Dundalk | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
7040 Dunbar Rd. | | | | d. STREET ADDRESS
7040 Dunbar Rd. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
Walter H. Wilver | | | | 4. DATE OF DEATH Month Day Year
October 15 1961 | | | | |
| 5. SEX
M | | 6. COLOR OR RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Jan. 28, 1899 | | |
| 9. AGE (In years last birthday)
72 yrs. | | IF UNDER 1 YEAR
Months Days | | IF UNDER 24 HRS.
Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
retired | | | 10b. KIND OF BUSINESS OR INDUSTRY
steel | | 11. BIRTHPLACE (State or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
George Wilver | | | | 14. MOTHER'S MAIDEN NAME
Cora Stahl | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
no | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Lillian E. Wilver, 7040 Dunbar Rd., Dundalk 22 | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Cornary Occlusion
 420.1 DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery dis.
 DUE TO (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH
 10 min
 2 yrs </div> </div> | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input "="" checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE Jack C. Collins M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) Jack C. Collins | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED
10-15-61 | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 22b. DATE THEREOF
Oct. 18, 1961 | | 22c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 22d. LOCATION (City, town, or county) (State)
Colgate, Md. | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Ullrich Funeral Home, Dundalk, Maryland | | | | 24a. REC'D BY REGISTRAR
DATE OCT 19 '61 | | 24b. REGISTRAR'S SIGNATURE
 | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11:58

1:00

| | | | | | |
|--------------------------------------|--|-------------------------------|--|-------------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | |
| 4. OCCUPATION | | 5. MARITAL STATUS | | 6. PLACE OF BIRTH | |
| 7. DATE OF DEATH | | 8. TIME OF DEATH | | 9. PLACE OF DEATH | |
| 10. CAUSE OF DEATH | | 11. MANNER OF DEATH | | 12. SIGNATURE OF EXAMINER | |
| 13. SIGNATURE OF ATTENDING PHYSICIAN | | 14. SIGNATURE OF CORONER | | 15. SIGNATURE OF JURY | |
| 16. SIGNATURE OF WITNESSES | | 17. SIGNATURE OF FUNERAL HOME | | 18. SIGNATURE OF BURIAL PLACE | |
| 19. SIGNATURE OF CHURCH | | 20. SIGNATURE OF CEMETERY | | 21. SIGNATURE OF INTERMENT | |
| 22. SIGNATURE OF OTHER | | 23. SIGNATURE OF OTHER | | 24. SIGNATURE OF OTHER | |
| 25. SIGNATURE OF OTHER | | 26. SIGNATURE OF OTHER | | 27. SIGNATURE OF OTHER | |
| 28. SIGNATURE OF OTHER | | 29. SIGNATURE OF OTHER | | 30. SIGNATURE OF OTHER | |
| 31. SIGNATURE OF OTHER | | 32. SIGNATURE OF OTHER | | 33. SIGNATURE OF OTHER | |
| 34. SIGNATURE OF OTHER | | 35. SIGNATURE OF OTHER | | 36. SIGNATURE OF OTHER | |
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| 40. SIGNATURE OF OTHER | | 41. SIGNATURE OF OTHER | | 42. SIGNATURE OF OTHER | |
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| 46. SIGNATURE OF OTHER | | 47. SIGNATURE OF OTHER | | 48. SIGNATURE OF OTHER | |
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| 73. SIGNATURE OF OTHER | | 74. SIGNATURE OF OTHER | | 75. SIGNATURE OF OTHER | |
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| 82. SIGNATURE OF OTHER | | 83. SIGNATURE OF OTHER | | 84. SIGNATURE OF OTHER | |
| 85. SIGNATURE OF OTHER | | 86. SIGNATURE OF OTHER | | 87. SIGNATURE OF OTHER | |
| 88. SIGNATURE OF OTHER | | 89. SIGNATURE OF OTHER | | 90. SIGNATURE OF OTHER | |
| 91. SIGNATURE OF OTHER | | 92. SIGNATURE OF OTHER | | 93. SIGNATURE OF OTHER | |
| 94. SIGNATURE OF OTHER | | 95. SIGNATURE OF OTHER | | 96. SIGNATURE OF OTHER | |
| 97. SIGNATURE OF OTHER | | 98. SIGNATURE OF OTHER | | 99. SIGNATURE OF OTHER | |
| 100. SIGNATURE OF OTHER | | 101. SIGNATURE OF OTHER | | 102. SIGNATURE OF OTHER | |

14

1

RECEIVED
FEB 15 1964
MASSACHUSETTS DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11200

11189

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY BALTO.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON
c. LENGTH OF STAY IN 1b 2 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1642 ABERDEEN | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD.
b. COUNTY BALTO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON
d. STREET ADDRESS 1642 ABERDEEN RD.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LETTIE CATHERINE WOOD | | 4. DATE OF DEATH OCT. 10 1961 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH APR. 18, 1881 |
| 9. AGE (In years last birthday) 80 yrs. | | IF UNDER 1 YEAR
Months 0 Days 0 | IF UNDER 24 HRS.
Hours 0 Min. 0 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sorter | | 10b. KIND OF BUSINESS OR INDUSTRY LAUNDRY | 11. BIRTHPLACE (County & State, or foreign country) PETERSBURG, VA. |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME GEORGE MYERS | |
| 14. MOTHER'S MAIDEN NAME ROSA V. BROCKWELL | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | |
| 16. SOCIAL SECURITY NO. 213-09-9249 | | 17. INFORMANT FLORENCE G. MORROW Address 1642 ABERDEEN RD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
331X DUE TO
Conditions, if any, which gave rise to immediate cause (b) Cerebral Arteriosclerosis
(c) Generalized Arteriosclerosis
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH 2 days
years | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (the hospital) attended the deceased from Sept. 21, 1961 to Oct. 10, 1961 , that (I) (we) last saw the deceased alive on Oct 9, 1961 , and that death occurred at 10:00 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Charles V. Sevcik M.D. | | 22b. DATE SIGNED 10/10/61 | |
| 22c. PHYSICIAN'S NAME (Type) DR. CHARLES SEVCIK | | 22d. ADDRESS 5101 BELAIR RD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 10/13/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER | | 23d. LOCATION (City, town or county) (State) BALTO. MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE George W. Hoffmann ADDRESS 3218 HUDSON ST. | | 25a. REC'D BY REGISTRAR DATE OCT 11 '61 | |
| 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11201

11190

| | | | |
|--|----------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
c. LENGTH OF STAY IN 1b <u>2 weeks</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Spring Grove State Hospital, Catonsville</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>
d. STREET ADDRESS <u>1250 Maple Ave.</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>William</u> Middle <u>H</u> Last <u>Wright</u> | | 4. DATE OF DEATH
Month <u>Oct</u> Day <u>1st</u> Year <u>1961</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>Wh</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7-3-1878</u> |
| 9. AGE (In years last birthday) <u>83</u> yrs. | | IF UNDER 1 YEAR
Months <u>83</u> Days <u>0</u> | IF UNDER 24 HRS.
Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>From Moulder</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>B. + O. R. R.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Owen Wright (dead)</u> | | 14. MOTHER'S MAIDEN NAME <u>Louise Wright (deceased)</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT Address <u>Mr. Melvin Wright (son)</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>possibly pneumonia</u>
DUE TO <u>450.0</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>bad nutritional state</u>
(c) <u>Generalized arteriosclerosis</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>SEPT. 29</u> , 19 <u>61</u> , to <u>OCT. 1</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>OCT. 1</u> , 19 <u>61</u> , and that death occurred at <u>2:55</u> AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Loretta Hsu</u> M.D. | | 22b. DATE SIGNED <u>10-1-61</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>LORETTA HSU</u> | | 22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>10/4/61</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Fouclow Park Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Imbrux, Inc. 1328 Sulphur Spring Rd.</u> | | 25a. REC'D BY REGISTRAR <u>OCT 4 '61</u> | |
| ADDRESS <u> </u> | | 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11191

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McDonogh School - Pikesville | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Clara Middle Younger Last Younger | | 4. DATE OF DEATH Month Oct Day 26 Year 19 61 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 1, 1887 |
| 9. AGE (In years lost birthday) 74 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY none | |
| 11. BIRTHPLACE (State or foreign country) Hebbville, Md. | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME William Riddle | | 14. MOTHER'S MAIDEN NAME Annie Zimmerman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 212-32-0658 | |
| 17. INFORMANT Mr William E. Younger | | Address Box 28, Md 5 Wumore Rd | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of pancreas
DUE TO 157X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) D
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1946 to Oct 26, 19 61 , that (I) was last saw the deceased alive on 24 Oct 19 61 , and that death occurred at 8 A.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Paul H Royse | | 22b. DATE SIGNED 26 Oct 61 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Paul Royse | | 22d. ADDRESS Pikesville 8, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 10/28/61 | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery | | 23d. LOCATION (City, town, or county) (State) Randallstown Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers | | 25a. REC'D BY REGISTRAR Arthur E. Kraw | |
| ADDRESS 8728 Liberty Rd. Randallstown, Md. | | 25b. REGISTRAR'S SIGNATURE Arthur E. Kraw | |
| DATE OCT 30 '61 | | | |

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CHIEF OF POLICE

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11203

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11192

| | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
e. STATE New Jersey
b. COUNTY Washington | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | d. STREET ADDRESS 215 Puch Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
RICHARD L. ZELLERS | | 4. DATE OF DEATH
October 2, 1961 | | 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/14/36 | | 9. AGE (In years last birthday) 24 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
truck driver | | 10b. KIND OF BUSINESS OR INDUSTRY
chemical | | 11. BIRTHPLACE (State or foreign country)
new jersey | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Henry Zellers | | 14. MOTHER'S MAIDEN NAME
Agnes Cryan | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
136-26-8605 | |
| 16. SOCIAL SECURITY NO.
136-26-8605 | | 17. INFORMANT
Address | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Crushing injury of chest with perforation of chest wall
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) xxxxx wall DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | INTERVAL BETWEEN ONSET AND DEATH | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
Ran into back of acid truck | |
| 20c. TIME OF INJURY
Month, Day, Year
xxx 10/2/ 19 61 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Pulaski Hwy. | | 20f. (City or town)
Baltimore, Maryland | | 20g. (County)
Baltimore | | 20h. (State)
Maryland | | 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
| ACTUAL SIGNATURE
Peter W. Rieckert | | EXAMINER'S NAME (Type)
Peter W. Rieckert, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> Medical Investigator <input checked="" type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED
10/2/61 | | 22a. BURIAL, CREMATION, REMOVAL (Specify)
removal | | 22b. DATE THEREOF
10/3/61 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Hillside Cemetery | | 22d. LOCATION (City, town, or country)
Washington N.J. | | 23. FUNERAL DIRECTOR
William E. Johnson | | 24a. REC'D BY REGISTRAR
OCT 4 '61 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | 24c. ADDRESS
1551 Northern Pkwy. | | 24d. (State)
Oxford | |

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New Jersey

Atlantic City

Atlantic City

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11204

11193

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reistertown | | c. LENGTH OF STAY IN 1b
18 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Berrymans Lane Box 328 Rt. 2 | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Reistertown | |
| | | d. STREET ADDRESS
Same | |
| | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First William Middle Clifford Last Zimmerman | | 4. DATE OF DEATH
Month Oct. Day 11 Year 19 61 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jul. 24, 1878 |
| 9. AGE (In years last birthday)
83 yrs. | | IF UNDER 1 YEAR
Months 83 Days 83 Hours 83 Min. 83 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
Construction | |
| 11. BIRTHPLACE (State or foreign country)
Ohio | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Jacob Zimmerman | | 14. MOTHER'S MAIDEN NAME
Mary Talley | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No. | | 16. SOCIAL SECURITY NO.
296-09-8452 | |
| 17. INFORMANT
Mrs. Frank Jones | | Address
Berrymans Lane Rt. 2 Box 328 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.
(b) DUE TO
(c) DUE TO | | | |
| INTERVAL BETWEEN ONSET AND DEATH
3 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
none | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
none | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m.
none | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> none | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
none | | 20f. (City or town) (County) (State)
none | |
| 21. I certify that (I) (this hospital) attended the deceased from 6-27-44 , 19____, to 10-11-61 , 19____, that (I) (we) last saw the deceased alive on 10-10-61 , 19____, and that death occurred at 8P M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
D. D. Caples | | 22b. DATE SIGNED
10-12-61 | |
| 22c. PHYSICIAN'S NAME (Type)
D. D. Caples, M. D. | | 22d. ADDRESS
6 Hanover Rd., Reisterstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Entombment | | 23b. DATE THEREOF
Oct. 16, 1961 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Pk. Mausoleum | | 23d. LOCATION (City, town, or county) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Wm. J. Tichauer & Son, Inc. North & E. Pk. Balt. 17 Sp. | | 25a. REC'D BY REGISTRAR
DATE OCT 13 '61 | |
| | | 25b. REGISTRAR'S SIGNATURE
Arthur L. Huns | |

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CERTIFICATE OF DEATH

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Number 44... Baltimore, Md.